DOCUMENT RESUME

ED 261 139 UD 024 444

AUTHOR	Douglas, Harry E., III
TITLE	Sharing: The Key of Networking. Proceedings of the Annual Conference of the National Society of Allied Health (Houston, Texas, March 30-31, 1984).
INSTITUTION	Charles R. Drew Postgraduate Medical School, Los Angeles, Calif.
SPONS AGENCY	Health Resources Administration (DHHS/PHS), Hyattsville, Md. Bureau of Health Professions.
PUB DATE	Mar 84
CONTRACT	HRSA-84-220(P)
NOTE	123p.
PUB TYPE	Collected Works - Conference Proceedings (021) -- Viewpoints (120)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*Allied Health Occupations; *Allied Health Occupations Education; Allied Health Personnel; *Black Colleges; Career Counseling; *College Planning; High Schools; Leadership; Minority Groups
IDENTIFIERS	*Networking

ABSTRACT

The topic covered at the 1984 annual meeting of the National Society of Allied Health (NSAH) was networking among schools of allied health and health related professionals concerned with increasing the numbers of minorities (Blacks, Hispanics, Native Americans) in the allied health and health related fields. This booklet is a compilation of the proceedings. The stated objectives of the meeting were to (1) identify benefits of sharing resources for the development and maintenance of allied health programs; (2) provide information and model programs for developing allied health programs; (3) identify and bring together key minority people in organizations involved in the field; (4) provide strategies for establishing a network between educational institutions in the field; and (5) promote minority participation in seeking leadership positions in the field. These themes were developed in the speeches given by a variety of professionals in the field from government and educational institutions. One paper was also presented which described a model health career counseling program for urban high school students. The proceedings conclude with a short note about the contributors and an address listing of participants. (CG)

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March 30-31, 1984
Texas Southern University
Houston, Texas

ED261139

"SHARING: THE KEY OF NETWORKING"

Prepared by:
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Pursuant to:
Contract# HRSA 84-220(P)

UD024444

Prepared for:

U.S. Department of Health and Human Services
Public Health Services
Health Resources Administration
Bureau of Health Professions
Division of Disadvantaged Assistance

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IN MEMORIAL

Dr. Donald T. Watson was a long time member and supporter of the National Society of Allied Health (NSAH), his untimely demise (April 17, 1984) occurred shortly after the 1984 NSAH's Annual Meeting. Dr. Watson's life work focused on making the American Health Care System more responsive to all Americans, particularly Black Americans. He was an outspoken advocate for major reforms in the health care delivery system. His pioneering efforts in developing Health Services Administration programs at Tennessee State and Florida A & M Universities contributed substantially to the increased pool of minority health professionals dedicated to the principles he espoused.

Indeed, his efforts have ensured a more promising future for all Americans. Dr. Harley Flack in his remarks in behalf of the NSAH, at the transitional service, shared words from a song which articulates what Dr. Watson was about:

"If I can help somebody
    as I travel on,
If I can cheer somebody
    with the words of a song
If I can show somebody
    he is traveling wrong,

Then my living shall not
    be in vain

Then my living shall not
    be in vain

Then my living shall not
    be in vain

If I can help somebody
    as I travel on
Then, my living shall not
    be in vain."

To ensure the legacy of Dr. Watson, the NSAH will sponsor a "Dr. Donald Watson Health Policy Forum" beginning in 1985. The Policy Address will be conducted annually at the Society's National meeting.

His living was not in vain!

ACKNOWLEDGEMENT

The publication of these proceedings was made possible by the efforts of the Conference Planning Committee, Dr. Harry Douglas, Dr. Algeania Freeman, Dr. Lucille Tunstall, Dr. Donald Watson, and local meeting hosts Dr. John Sessions, and Dr. Evelyn Scott; Business Services, Etc., Inc., the officers and members of the Board of Directors of the National Society of Allied Health; and support of Dr. Clay Simpson, Jr., Director, Division of Disadvantaged Assistance, Bureau of Health Professions, HRSA, Rockville, Maryland and Mr. Walter Levi, Project Officer, who supervised the Contract #HRSA 84-220(P) from the Division of Disadvantaged Assistance, HRSA. Most importantly, we acknowledge the contributions and efforts of the conference presenters.

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NATIONAL SOCIETY OF ALLIED HEALTH
ANNUAL MEETING
MARCH 31-31, 1984

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CONFERENCE OVERVIEW

NATIONAL SOCIETY OF ALLIED HEALTH

By

Harry E. Douglas, III, D.P.A.
Dean, School of Allied Health
Charles R. Drew Postgraduate Medical School
Los Angeles, California

The National Society of Allied Health (NSAH) held its Annual Meeting at Texas Southern University on March 30-31, 1984. The meeting was appropriately entitled: "Sharing: The Key to Networking." The theme was selected to stimulate the development of action strategies designed to encourage more cooperation between schools of allied health and health related professionals concerned with increasing the numbers of minorities - Blacks, Hispanics, and Native Americans into the allied health professions.

In planning for the meeting the Executive Board of the National Society of Allied Health felt that given the lack of minority representation in the allied health field, that a meeting with the objective to foster networking was a timely topic. A number of the NSAH members were participants in the American Association of State Colleges and Universities (AASCU) project for technical assistance for Allied Health program recruitment and counseling in minority colleges. The goal of the AASCU project was to be accomplished by providing technical assistance to schools of allied health to enable schools with minority focus to initiate allied health programs and promote inter-institutional linkages for allied health activities. It was also an objective of the project to assist the participating institutions to obtain outside foundation funding and/or federal support in furtherance of the project objectives.

As the project developed it was discovered that such funding was not forthcoming. Hence, while there was a considerable amount of enthusiasm generated as a result of the project activity, there was little support from the external environment to support continuing AASCU generated project activities. It therefore became evident that in order to increase the numbers of allied health programs as recommended by the AASCU program, that those institutions which were concerned with the issue would necessarily have to build stategies of self-determination and self-reliance among themselves. Specifically, strategies would need to be developed whereby institutions with allied health capabilities and capacity would need to explore ways to share information and resources, a forum to promote this notion should be the NSAH annual meeting. But why the National Society of Allied Health?

It is generally recognized that traditionally Black institutions and institutions of higher education which serve predominantly minority populations are in the vanguard in terms of educating and training minority allied health professionals. This has been the trend throughout the course of American history and will undoubtedly continue into the distant future and while this trend will continue, it will have a negligible impact in terms of reversing the underrepresentation of minority group members particularly at the upper levels within most allied health occupational clusters, namely, in the leadership positions. Therefore, universities serving Black and other minority populations must continue to serve as the major national supplier of Black allied health professionals while increasing their efforts to educate minority health professionals if they are to effectively service the country's health needs.

In this regard the National Society of Allied Health, which was incorporated in June, 1978, formed to promote excellence in allied health education for minority students at traditionally Black institutions, predominately Black institutions, and other institutions concerned with minority allied health manpower. It was therefore appropriate then, that the Division of Disadvantaged Assistance, U.S. Department of Health and Human Services would support a project to record the proceedings of this meeting. The conference objectives were to:

1. identify benefits of sharing resources in the development and maintenance of allied health programs,
2. provide information as well as the model programs for developing allied health programs,
3. identify and bring together key minority persons in organizations involved in allied health,
4. provide action recommendations and strategies to establish a network among and between institutions concerned with educating minority group members in allied health, and
5. promote minority participation in seeking leadership positions within the allied health field.

The conference was successful, the discussions were stimulating and enlightening, the proceedings speak well of the level and quality of the conference, and go a long way towards identifying problems facing the dearth of minority participation in allied health careers but more importantly, recommending action strategies designed to improve minority participation in the allied health arena.

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February 28, 1984

Dr. Everlena Holmes, President
National Society of Allied Health
P.O. Box 495
Howard University
Washington, D.C. 20059

Dear Dr. Holmes:

Enclosed you will find the health editorial for the Allied Group Health Meeting in Houston on March 30th.

I am very sorry that I will be unable to attend the conference; please convey my apologies to your membership.

Thank you very much for your kind invitation. It I can be of assistance in the future, please do not hesitate to call me.

Sincerely,

Mickey Leland

MICKEY LELAND
Member of Congress

ML:ryn
enclosure

WASHINGTON OFFICE—419 CANNON HOUSE OFFICE BUILDING, WASHINGTON, D.C. 20515, (202) 225-3816
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Thank you very much for the opportunity to address your fine organization. I am very sorry that I am not able to attend the Allied Health Group Meeting in person, for as allied health professionals you have, in my opinion, chosen among the noblest of careers. You have chosen to give your time, training, heart, and devotion to those who are ill and need the compassionate hand of the healer. Not everyone can do what you do; not only because they don't have your training, but because not everyone can be as giving and unselfish as you must be in your professions.

The provision of health care is still, sadly, not at the top of the list of society's goals. It is still easier to win support for massive expenditures on the instruments of nuclear death than it is to gain favor for funding for medical research to extend life. It remains a disturbing fact of life in America that our ability to obtain the basic medical care necessary for good health is dependent on wealth, rather than the advances of our technology. What saves us are the many fine professionals, such as yourselves, who are dedicated to providing the best care possible, regardless of the economic or social status of those who need care.

As minority Allied Health Professionals, you have a vital role to play in bringing about a reversal of the policies which have dashed the hopes of so many; you can be effective in restoring decency back into the health care policies of the federal government. As respected members of your communities you have an opportunity, and more importantly, a responsibility to this mission. I urge each and every one of you to take an active role in this battle. Contact your Representative, establish a dialogue; the Congress needs to be aware of the particular concerns of minority allied health professionals.

Again, thank you very much for this privilege. I extend my best wishes to all of you and stand ready to assist you in your endeavors.

MICKEY LELAND
Member of Congress

THE PRESIDENTIAL ADDRESS

THE HEALTH STATUS OF BLACK AMERICANS: A CHALLENGE FOR ALLIED HEALTH PROFESSIONS IN THE 80'S

By
Everlena M. Holmes, RRA, Ed.D.
Allied Health Administration
The George Washington University
Washington,D.C.

Historically, Blacks and other minorities have been underrepresented in the allied health professions. It is felt that this underrepresentation has ultimately affected the quality of health care services provided Blacks and other minorities.

Although there has been an effort on the part of the federal government to correct the inequities in the representation of minorities in health professions, this has primarily been directed toward minorities entering medical schools. The 1985 proposed Reagan budget seeks to increase funding for special assistance for disadvantaged individuals to attend medical schools (1). This example depicts the attitude and lack of action taken by Congress to also seriously consider the need for minorities to enter the allied health professions. Among the few exceptions is the Health Careers Opportunity Program (HCOP).

The Health Careers Opportunity Program was designed to attract and assist minorities to successfully complete health profession programs. However, federal priorities for funding these programs have been in non-allied health areas. Black colleges and universities seeking HCOP funds find that they are at an unfair disadvantage in competing with non-allied health programs for funds that are needed so desperately to develop and maintain undergraduate allied health efforts. These institutions have had to look increasingly more to state, private, and Title III funds (Aid to Developing Institutions) for implementing and maintaining undergraduate allied health programs. The 1985 Reagan budget, however, proposes to shift the emphasis of the Developing Institutions programs so that less money would be spent on specific projects and more on helping to build up endowments of Traditionally Black Institutions.

As funding each year for allied health education is given less and less priority by the federal government, allied health programs at Black colleges and universities suffer gravely. In fact, the number of allied health programs offered by these institutions has declined since 1975, from 310 to 219 in 1980. Naturally, this has affected the percent of Blacks enrolled in allied health education programs, which declined from 10.1 percent in 1975 to 8.7 percent in 1980 (2). Although, the number of minority students in allied health profession schools rose between 1972 and 1979, the preponderance of Black students in allied health profession schools has begun to decline. It would appear that the continuing trend toward poor health for Blacks and other minority Americans would justify the need for federal legislation to support and encourage minorities to enter allied health professions. It would also appear that this factor would provide an incentive for Black colleges and universities to implement undergraduate allied health programs.

Several authors have indicated that barriers to health care exist for minorities due to the limited number of minorities in policy making positions. As a result, racial discrimination operates subtly and overtly--inhibiting access for minorities to adequate health care services (3). According to Dr. Christmas, Commissioner of the New York City Department of Mental Health and Retardation Services in 1977, this lack of accessibility, availability, and appropriateness of health care for minorites is indicative of a situation in which minorities do not share proportionately in policy making. As a result of the lack of minorities involved in the administration, planning, and financing of health care, the accountability to these ethnic minorities is seriously lacking (4). We must, therefore, encourage broader participation among minorities in allied health in conducting research, publishing, and keeping congressmen informed of the needs and concerns of minorities in the allied health professions.

Several studies, reports, articles, and statements have been written on the need for minorities to enter the health professions. These references, however, have been directed toward minorities entering medicine, optometry, dentistry, veterinary medicine, osteopathy, pharmacy, podiatry, public health, nursing, and graduate health profession programs. Therefore, primary and priority federal funding has been provided for these groups of health professions. We, as minorities in the allied health professions, may feel that Congress has an obligation and a responsibility to establish and support policies on our behalf. However, it is important that we also recognize and accept our responsibilities as minorities in allied health. As minority health professionals, it is our responsibility to keep our congressmen informed of our needs and concerns on specific issues affecting us as a group. Congressmen are not specialist in all areas. Therefore, they rely heavily on their constituencies to provide them with the resources they need to help make policies. If we are to have our needs and views represented or supported by Congress, we must, therefore, be perceived as a constituency of Congress. If we fail to become involved in the political arena, then we must also accept some of our fate as minorities in allied health.

We have spent the past day and a half sharing our ideas with each other and making recommendations for change. What we do with this information, once we leave this meeting, will primarily be left up to each of us. If we care, if we have a sincere commitment, and if we see a need for change, we will take action. Each of us can single-handedly serve as a catalyst for change. We can find the time in our busy schedules to do whatever is necessary to create change. We can conduct research, write articles, attend congressional hearings, support our congressman, and let them know our needs and concerns. We can attend our professional meetings and become actively involved in professional activities and governance. Finally, we can continue to share ideas and resources through networking. By talking, writing and giving more to each other, together, we can accomplish a great deal.

The National Society of Allied Health offers you an opportunity to get involved in creating changes in the health status of minorities, become more visible as a minority leader, and to share your views on issues relating to minorities in allied health. Through your active participation in The National Society of Allied Health, you will grow professionally and as an individual. Your participation is needed to help minorities to help themselves. Why not share your many years of experience with others. There is a wealth of knowledge and expertise in this audience and there is a tremendous need for this knowledge and expertise to be shared with other minorities.

We as minorities in allied health can help each other by establishing network systems between allied health professionals, allied health education programs, organizations, and agencies that are concerned about minorities in allied health. Network activities are especially needed among Black colleges and universities. These institutions have proven their ability to produce Black professionals to meet the needs of the Black community and the nation as a whole (6). Black colleges and universities are viewed as a valuable national resource. Hence, with the proper leadership and resources, these institutions can continue to respond to the demand for Blacks and other minorities in allied health professions.

As we leave this meeting, remember the need to S H A R E! Sharing is not only the key to networking, it is also the key to the survival of a nation.

- A Healthy Nation is a Productive Nation -

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KEYNOTE ADDRESS

NETWORKING IN THE CONTEXT OF A POLITICAL RACE FOR SURVIVAL

Patrick R. Wells, Ph.D.
Dean, School of Pharmacy
Texas Southern University
Houston, Texas

I am deeply honored by this opportunity to serve as the Keynote Speaker for this 1984 Annual Meeting of the National Society of Allied Health.

The focus of this particular conference is on networking and the role that it can and should play in promoting excellence in allied health education among the member institutions of NSAH. Quite simply, we are talking about the sharing of our diverse institutional resources for a common good.

As your keynoter, I wish it were possible to inform you at the outset of my remarks that I stand here this evening with the answers that you seek and which you so desperately need. Unfortunately, I have no such answers.

What you should be sharing, and how you should go about sharing it, are questions that only you can answer. Hopefully, you will conclude this Annual Meeting with some significant progress towards developing the answers to these and other questions.

There is, however, one overriding question for which, in my judgement, we already have an answer; namely, whether a need for networking actually exists among the member institutions of NSAH. The answer, obviously, is "yes," it does. And it is my purpose this evening as keynoter for this conference to not only impress upon you some of the reasons why this is so, but also to impress upon you the fact that networking might well hold the key to the very survival of the National Society of Allied Health and its member institutions.

In recent decades impressive gains have been made in meeting the health care needs of all Americans, including minorities. But as impressive as these gains have been, important differences still exist between majority and minority Americans in a number of areas. To cite just a few:

- The life expectancy for Blacks is approximately five years less than what it is for Whites.

- Infant mortality for Blacks is twice what it is for Whites.

- Blacks are more likely to suffer and to die from hypertension, from strokes, and from certain types of cancer than are Whites.

These are just a few examples of continuing Black/White differences in the area of medical care. The situation in dental care is even worse, where still greater disparities exist between Blacks and Whites in their utilization of dental care.

Even more marked, however, are the differences that persist in the areas of health manpower. Notwithstanding the considerable progress of recent decades, Blacks in 1980 accounted for 11.7 percent of the total population, but only 2.6 percent of all practicing physicians.

In 1980, Blacks accounted for only 2.9 percent of America's active dentists, for only 2.3 percent of the nation's pharmacists, and for only 1.6 percent of the country's veterinarians.[1]

And these are the statistics for just your primary health areas. I need not point out that comparable statistics are reported for all areas of allied health care, which are the areas of particular concern to this conference.

Clearly, all of these statistics underscore the need for a continuing concern with minority health care and with minority health manpower both in the primary and allied health areas.

Our special concerns are with providing minority health manpower, and with providing it by means of the minority institutions with which we are associated.

This, of course, raises the inevitable question of whether there is actually a need for minority or predominantly Black colleges and universities.

On the one hand, we are the first to insist that Black students have a fair chance of admission to institutions that are predominantly White.

On the other hand, we actively seek to preserve the racial identity of schools that have long been, and continue to be predominantely Black.

---

[1] Association of Minority Health Professions Schools, Blacks and the Health Professions in the 80's: A National Crisis and a Time for Action, June, 1983, pp.5-8.

There are those who see these two goals as somehow incompatible and who wonder if it might not be best to close our minority institutions and to thereby concentrate all our efforts and resources in the majority institutions alone.

We, of course, disagree. This is because we know that the two goals for which we strive merely seem to be irreconcilable with a third and overriding goal. It is, as William V. Thomas explains the goal, "To give Blacks the widest possible opportunity of a college education in an environment suited to their needs."[2]

Stated differently, and put more simply, Black students, because of their special backgrounds, are more likely than White students to need a special educational nurturing that only our minority institutions can provide.

There is, though, still another reason in support of the continuing need for our predominantly Black colleges and universities. In all areas of primary and allied health manpower, minorities in general, and Blacks in particular, are under-represented.

There is, then, the persistent need to ensure the greater recruitment and training of Blacks and other minorities in all areas of health manpower. And it is our predominantly Black colleges and universities that will best ensure the continuous and concerted pursuit of this goal.

About this there is no doubt, notwithstanding the progress that has been realized from twenty years of civil rights and affirmative action policies. A June, 1983, study sponsored by the Association of Minority Health Professions Schools concluded the following:

> "It is clear from the data that some majority schools (in all fields but veterinary medicine) have achieved success in recruitment, retention and graduation of minority students. It is also obvious from the data that a very small proportion of majority schools is responsible for increases in Black enrollment. The preponderance of health professions schools has made little progress in increasing minority enrollment."[3]

Quite clearly, any future impetus for a growth in the recruitment and training of minority health manpower must and will come from our predominantly Black institutions offering programs in this area.

---

[2] William V. Thomas, "Plight of America's Black Colleges," Editorial Research Reports, Jan. 23, 1981, p. 40.

[3] Blacks and the Health Professions, p. 27.

In cases of allied health manpower, this impetus must and will come from the institutions represented here this evening; namely, the member institutions of the National Society of Allied Health.

But providing this impetus for a continued growth in allied health manpower will not be an easy task. In fact, rapidly changing conditions suggest that the challenge confronting you will be an even more difficult one.

We have confronting us, for example, the problem of changing enrollment patterns. During the 1970's, the Black student population attending America's colleges and universities increased by 275 percent. In 1979, the Census Bureau reported that Blacks accounted for 10 percent of all college students, which was just slightly below their 13 percent overall proportion in the population. The Census Bureau also reported in 1979 that our traditionally Black colleges, which twenty years earlier enrolled 96 percent of all Black college students, were now enrolling fewer than 20 percent.[4] Clearly, with the growing entry of Black students into predominantly White institutions, our Black colleges, already hard pressed, have found themselves face to face with a struggle for survival. It is a struggle that clearly continues.

Even worse, however, is that financial support for Black colleges has always been lower than that for comparable White colleges. It happens, however, that Black colleges today find themselves in need of increased funds in order to improve their facilities and services not only to accommodate growing Black aspirations, but also to accommodate the federal regulations that today require our traditionally Black colleges to attract more White students.

We've never had enough money, yet we find ourselves in a situation where we need even more money at a time when money is becoming even more difficulty to come by. Compared with White institutions, Black colleges receive less income from student tuition and fees. The result is a greater reliance on public sources of support in general, and on the federal government in particular.

I need not tell you that the patterns of federal aid to higher education are ever changing; I need not tell you that at the present time we are observing a retrenchment in federal support for higher education; and I need not tell you that as a result of these fluctuating patterns in federal support for higher education, more and more of our traditionally Black colleges find themselves with budget deficits that cannot be made up from endowments that in most cases are only meager at best.

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[4] William V. Thomas, "Plight of America's Black Colleges," Editorial Research Reports, Jan. 23,1981, p.39.

I need not tell you that the member institutions of the National Society of Allied Health are these traditionally Black colleges of which we speak; and I need not tell you that these problems of enrollment and of financing will continue to challenge your efforts to promote excellence in allied health education for minority students.

It perhaps would be nice if these were the only problems confronting us, but unfortunately this is not the case.

Compounding these and other problems, for example, is the growing consensus that in the not too distant future a number of health areas will suffer not from a shortage of health manpower, but rather from a surplus of health manpower. The implications of any such surpluses are clear; namely, an even greater reduction in this country's financial support for health education. There is no suggestion of any surplus in minority or Black health manpower, but neither is there any guarantee that any reductions in financial support resulting from these surpluses will not affect our Black colleges and their health education programs for minority students.

Our traditionally Black colleges are today showing a will and a determination to survive. They differ widely in size, in endowments, in affiliation, in sources of support. It is likely that not all of them will survive. But those that do will be the institutions that best adapt themselves, in creative and imaginative ways, to the changing circumstances with which they find themselves confronted.

Representing as it does component parts of these Black colleges, the National Society of Allied Health has a direct share in this struggle for survival. It is simply that its focus is a bit narrower and has as its immediate concern the survival of excellence in allied health education for minority students.

It happens that the parts cannot survive without the survival of the whole, and it happens that the whole cannot survive without the commitment and cooperation of the parts.

It is, then, in this perspective of a struggle for survival that we can and should view the National Society of Allied Health and its concern for networking or the sharing of member resources for a common good.

And, again, what confronts us at this conference is not a question of whether there should be networking, for there clearly is no alternative to it. To the extent that networking can strengthen our programs of allied health education for minority students, and do so when such programs are threatened by such problems as declining enrollments and the loss of financial support, then to that extent will networking contribute to the survival of the NSAH and to the survival of the Black colleges and universities of which it is a part.

What types of networking programs are needed, and how such programs can be implemented, are questions that you must answer. They are difficult questions for which no easy answer exists. But you are here, you are asking the questions, and I am confident that you are on your way to finding the answers that we so desperately need. And I applaud you for your efforts in doing so, for while networking is not the solution to all our problems, there is no question but that it is a necessary step in that direction.

In concluding, I would like to remind you that we are a part of a proud tradition. One born in blood, sweat, and tears. It is our responsibility to assure the many Black men and women who come after us, that they too will have the opportunity to become a part of the many professions gathered here this evening. I am certain we will not let them down. Please accept my best wishes for the most successful convention. Thank you.

RESPONSE TO KEYNOTE ADDRESS

By
Donald F. Taylor, Sc.D., Dean
School of Health Related Professions
and National Sciences
Norfolk State University
Norfolk, Virginia

It is very difficult to respond to such a stirring and provocative address as we have just heard. However, I have been given that charge and I shall attempt to do so.

Our speaker, Dr. Patrick Wells, has given us much food for thought this evening. He began by answering the question on the necessity for networking. He stated in the affirmative that indeed networking was a timely and necessary process. He cited as evidence that at least two compelling reasons exist for networking. First, he said, the differences that currently exist in the areas of medical care, culturally expressed disease, within the minority health care systems and regarding health manpower--all speak to the necessity for a viable network to attend to these specific differences as expressed in the Black or minority population. Secondly, Dr. Wells cited the need for continued evidence to sustantiate the critical need for minority schools, such as predominatly Black institutions.

The network assures several things, the first of which is a fair chance for admission to all schools; secondly, a network would help sustain the conclusion that the racial identity of traditionally Black institutions must be preserved; third, the network would help assure the widest possible effort of college education for all Blacks; and fourth, the network would be a viable symbol in assuring that Traditionally Black Institutions (TBI's) will continue to be in the forefront of making sure that there is access to college for all people. Networking can help in these and many other ways.

It is rather unfortunate, as Dr. Wells pointed out, that as we begin to look at some of the problems we are facing, there is a decided change in the enrollment pattern. Traditionally Black Institutions, which used to enroll the majority of minority students, now enroll less than 20 percent of all Black students. This is down from a high of 96 percent enrollment of Blacks in TBI's in the past years. Dr. Wells also stated that there is a drastically changed financial picture. Money is getting scarcer and scarcer, at a time that the TBI's are needing more and more to improve facilities, services, and meet the problems of increased federal regulations. Furthermore, as Dr. Wells pointed out, the changing patterns of health manpower supply assures that while there may be talk of a surplus of health manpower in other races, there is no surplus of minority health manpower.

The speaker has emphasized that the NSAH has a definite role in its constant struggle for existence. "Networking", he said, is a goal well worth continuing to develop. Networking could positively and significantly contribute to the basic ongoing struggle for continued existence of the Black schools. Finally, Dr. Wells issued the challenge to NSAH to continue its efforts in this regard.

While the questions are quite apparent, the solution to these questions are not quite so apparent. He concluded by saying that the National Society of Allied Health is here today not only to ask the questions but to seek the answers. The internal process of forging those answers is difficult but the process is necessary. "We are the people of proud traditions," Dr. Wells reminds us. Networking can give tangible voice to this worthy tradition. Our speaker then congratulated the NSAH and said we should congratulate ourselves for having the foresight to look down that long tunnel of time and see a need, and then respond to that need in terms of survival. Networking is something that must be done if we are truly to survive as a people and as a concept.

On behalf of the NSAH, I would like to say thanks to Dr. Wells for having brought these thoughts to us. Without a doubt, he has certainly given us something to think about and a job to "get on with." God Bless You and Thank You.

TRADITIONALLY BLACK INSTITUTIONS OF HIGHER EDUCATON: THE MISSION, ROLE AND FUNCTION FROM A SOCIETAL PERSPECTIVE

Harley E. Flack, Ph.D.
Dean
College of Allied Health Sciences
Howard University
Washington, D.C.

By the way of introduction to this panel presentation on the Role and Mission of Historically and Predominatly Black Institutions (HPBI's), I would like to draw a brief historical perspective as we discuss and plan the future of allied health in our institutions. We gather here in Houston as agents of change and leadership in our institutions. Yes, you, like Mary McLeod-Bethune, Booker T. Washington, and General O. O. Howard, can help lead our HPBI's into a new era of challenge and achievement.

In reflecting on the past 125 years, we have witnessed our HPBI's responding to the pattern of problems and challenges in the education of Black Americans which parallels the phenomena described by Toffler in Third Wave and Nesbit in Megatrends. One-hundred twenty-five years ago, Black Americans were slaves. Between 1850 - 1950 three categories of Black institutions, namely, industrial schools, normal schools, and colleges/universities responded to three key educational needs of Black Americans.

First, industrial schools attempted to train Black people to develop job skills which could be used in the booming industrializing American society. The Black industrially oriented institutions contributed greatly to Black achievement in our society. In 1900, there were 13,000 Black students receiving industrial training in Black institutions. The importance of these institutions are cited to be:

> "Somebody must push the saw and drive the plane. Moreover, the demands for skilled labor becomes more and more imperative. Unless the ranks of the colored mechanics and artisans are filled, the South and the Nation will be flooded with an influx of foreigners. Such a condition would be dynamite and assassination of Black Americans."

Second, Black normal schools prepared a cadre of educators to teach in America's "separate, but equal" school system from elementary to university levels. In 1900, there were 4,514 colored students studying to become teachers, 1902 males and 2,612 females in 73 normal schools.

Third, higher educational institutions, those to which we refer as HPBI's today, prepared Blacks for the professions of medicine, law, religion and a few others. There were 32 Black Institutions having the designation of college in 1900. Within these colleges, 1,166 Black students were studying in the learned professions, 1,028 males and 138 females. The professional breakdown was:

585	Theology
310	Medicine
55	Law
45	Pharmacy
25	Dentistry
8	Engineering
25	Nursing

From those beginnings reflected in the above statistics on the three types of Black institutions, the success which we as Blacks claim in 1984 is attributable to the success of our Black institutions. As successful as our Black institutions have been, they are faced with even greater challenges today.

Toffler and Nesbit report in their books, American society has been undergoing dramatic changes over the past 20-30 years. According to the authors, we are moving from an industrially-based to a technical/service-oriented society. Just as they have always done, Black institutions must provide leadership in preparing Blacks to compete successfully in our hi-tech, service-oriented world. Correspondingly, Black industrial and normal schools have vanished from our society leaving only Black colleges/univerisites, which also are on the list of endangered species, to assist us in this transitional period.

In order to cope successfully during this transition, Blacks will not have the luxury of sitting back and relying on the vision and leadership of a college/university president. Black institutions have become a business in and of themselves to the extent that the majority of the chief executive's energies must be devoted to managing "the business." We educators are therefore challenged to supply vision and leadership to move our departments, divisions, schools and colleges to the cutting edge of advancement and innovation. Our strategies must include:(1) analyzing needs; (2) planning innovative programs;(3) implementing and managing programs; and (4) evaluating our success and making necessary corrections in our strategies; and (5) of course, networking.

Commencing these strategies is our challenge in Houston. The NSAH is providing a unique response to assist us in meeting these challenges. Via this meeting, we can initiate a system of networking and resource sharing where by our own and each others boot straps, we can pull our institutions up and successfully into the future.

In closing,I would like to read a poem which captures the zeal and direction which I feel the NSAH must adopt in facing our future:

WE ARE RISING

Among the sayings of our race,
  Suggestive and surprising,
That fill a most exalted place,
  Is, "Tell them we are rising!"

The question asked for right and truth,
  What to the North your greeting?
The answer from a Negro youth,
  "Tell them we are rising!"

Within Atlanta's classic halls,
  This youth, self-sacrificing,
Wrote high his name upon her walls,
  His motto: "We are rising!"

Out in the world he makes his mark,
  Danger and fear despising,
E'er soaring upward like the lark,
  My brethren: "We are rising!"

He meets the foe with voice and pen,
  With eloquence surprising!
Give us a chance, for we are men!
  Most surely we are rising!

Rising to take our place beside
  The noble, the aspiring;
With energy and conscious pride,
  To the best things, we're rising!

Within the classroom is his place,
  Greek, Latin, criticizing,
To raise the youthful of his race,
  and show the world we're rising!

Go forth, my friend, upon your way,
  Each obstacle despising,
Prove by your efforts every day
  To all that we are arising!

In farming, trade and literature,
  A people enterprising!
Our churches, schools, and home life pure,
  Tell to the world we're rising!

TRADITIONALLY BLACK INSTITUTIONS OF HIGHER EDUCATION: THE MISSION, ROLE AND FUNCTION FROM A SOCIETAL PERSPECTIVE

Remarks by
Carol J. Smith*

Thank you for the opportunity to informally talk with you for a few minutes on the topic, "Traditionally Black Institutions of Higher Education: The Mission, Role and Function from a Societal Perspective." Now this is quite a title you have assigned me, and I must admit that I was torn between giving a purely academic presentation, full of statistics, or one which I shall call a socio-realistic presentation with philosophical overtones. What follows is somewhat of a mixture.

Let's begin with some definitions. If you were to inquire as to the number of "Traditionally Black Institutions of Higher Education," (IHE) you may get a number that ranges from 100 to 105 or maybe 113. It all depends on who you ask and from what perspective the respondent answers. One list might include all institutions of higher education regardless of their current racial composition which were established to educate Black people. Another list might include selected IHE's which have become predominantly Black because of the geographical locations, although they were originally founded for the general population. Just so we are thinking about the same subset of institutions, I am using the definition of Historically Black Colleges (referred to as HBC's used by the former National Advisory Committee on Black Higher Education and Black Colleges and Universities). It is those institutions that were founded primarily for Black Americans although their Charters were, in most instances, not exclusionary. These are institutions serving or identified with service to Black Americans for at least two decades, with most being 50 to 100 years old. The Committee's list of HBC's omitted those IHE's which had become predominantly White in recent years. This omission does not negate their history and tradition as Black colleges; however in the strictest sense, they are no longer predominantly Black and are not included in the main set of institutions which continue to have a predominantly Black student body.

Now even with this definition, we are not speaking of a homogeneous set of institutions. Some HBC's are quite small, enrolling only a relatively few number of students; some have student bodies in the thousands. Some are located in rural settings while others like Texas Southern University are located in large metropolitan areas. Some are two-year institutions while the majority are four-year institutions and some are professional schools. Some have very strict admission standards whereas other have more relaxed standards. Some offer degrees in only a few areas whereas others afford multiple choices of majors. But what they all have in common is their mission, that of taking students where they happen to be academically and helping them to go as far as they can. Hence, some students graduate in four years and others may take five or six years to complete a bachelors degree. The mission of HBCs is to increase the number of Black Americans able to assume full citizenship status as working, taxpaying persons with a sensitivity to what it means to be a minority in these United States of America. They were founded in response to American racism and the reasons for their existence continue since for the majority of the more than 30 million Blacks in this country their economic, social, political, cultural and educational life is far different from that of the majority (White) population.

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*These remarks were made by Mrs. Carol J. Smith in her private capacity. No official support or endorsement by the Department of Education is intended or should be inferred.

Now, how well are these institutions carrying out their mission?

1. If Black colleges did not exist there would be a substantial decline in the number of Blacks earning baccalaureate degrees. It is a fact that the vast majority of Blacks now attending colleges are enrolled in institutions which were virtually closed to persons of color prior to the Supreme Court ruling of 1954. Less than 20 percent of all Blacks in college now attend the HBC's. More than half enter higher education through the two-year institutions, where tuition is low where there is easier access and proximity to their homes. And yet, close to one-third of all Blacks earning a BA or BS degree graduate from one of the 83 four-year HBC's while the 2,000 other four-year IHE's graduate the other 60 percent. Black colleges have contributed the major share of Black business executives, engineers, military officers, physicians, dentists, federal judges and federal government workforce.

2. HBC's are sanctuaries where Blacks of talent may practice their professions away from institutional discrimination. At Howard University's 1984 Charter Day Dinner, an award in music and entertainment was presented to Harold Wheeler, a 1964 graduate from Howard Unversity with a Bachelor of Music Education. His theater credits as conductor include the Broadway musicals "Promise, Promises" and "Dreamgirls," and his credits as orchestrator and musical supervisor include "CoCo," "Two Gentlemen of Verona," "The Wiz," and "Lena Horne - The Lady and Her Music." In accepting the award, Mr. Wheeler recalled how his high school

counselors tried to steer him to several well known predominantly White schools. But he chose Howard where he could not only learn his trade but have his self-confidence bolstered. This came in handy when he landed in the dog-eat-dog atmosphere of Broadway. While at Howard he was able to learn all aspects of theatrical productions including scenery, set contruction, lighting, and sound amplification, and was able to direct a number of musicals produced by the Department of Drama. This is far different from what happened to a number of extremely talented Black musicians whose spirits were crushed after less than two years at the prestigious White schools.

3. Then, too, HBCs provide a platform to give credence to Black leaders. It is the HBC's which consistently offer platforms to leaders such as Marion Berry, Julian Bond, Ben Hooks, Jessie Jackson, John Jacobs, Vernon Jordan, Joseph Lowery, and Andrew Young. When the White press says these and other Black leaders have lost touch with the Black masses - they can then address a capacity hall and the loud applause rings out to say this is one of our mature, responsible, able Black spokespersons. A by-product of this is the gaining of respect for Black leaders and the attainment of wholesome perspectives for the students as a result of having heard firsthand some the the great minds of our country.

4. Further, if there were no HBCs, about one-third of all Black faculty in higher education would have to look elsewhere for employment. Sixty-two percent of all Black higher education adminstrators in states where HBCs are located are employed by the HBC's. This percentage drops to about five to six percent in states where no HBC's are located. HBCs were the original practitioners of integration (where the law allowed) and even now are good examples of multi-racial faculties and student bodies.

5. They have been models for educating multicultural and multiracial student bodies. All races are welcome regardless of previous condition of servitude or social standing. They have long been dedicated to improving the educability of everyone. It is no accident that people of color from all over the world come to HBCs for an education. They come because they know that the color of their skin will not be a barrier to fulfillment of their educational potential. White Americans also benefit from experiencing firsthand what it means to be a minority. Also, the HBC's provided opportunities for the socioeconomically disadvantaged. They have been in the forefront of eliminating disparities and inequities

between Whites and Blacks by preparing Black Americans to enter the mainstream of society as a result of obtaining higher education. For several decades they have provided access and opportunity for Blacks to attain a higher education -- no matter how modest their circumstances. These institutions are unique in that they enroll a disproportionately large share of the Nation's economically disadvantaged students. Tuition and fees are kept low so that coupled with federal financial assistance, the cost of college education is within closer reach. It is believed that the financial aid officer at an HBC is more likely to try to put together a financial aid package for a Black youth and will give that extra help to enable the student to acquire the necessary skills and knowledge to become self-sufficient.

6. Black colleges have played a larger roll in sensitizing the nation regarding Third World and other leaders. Just recently, the President of France, Francois Mitterand, at his own request, was hosted by Mayor Andrew Young in Atlanta -- often a stopover for foreign dignitaries. When Andy was the U.S. Ambassador to the U.N., he was most effective in dealing with many Third World leaders because he had either been to school with them or could identify with them because so many of them had received some part of their education in HBCs. Lincoln University in Pennsylvania and Howard University are notable in having educated many persons who assumed leadership roles in emerging nations in Africa and the Caribbean. The 1890 institutions such as Prairie View, Southern, and Tennessee State have strong links with nations which have newly acquired their independence and need help in developing their natural and human resources.

Several years ago, the Washington Post listed leaders of nine African and Caribbean countries who either visited Howard within recent years or were shaped by Howard. The Howard connection in foreign countries goes far deeper than education of and contact with their leaders as a significant percentage of the population of Third World countries matriculated at Howard.

Recently you have heard about the financial plight of several HBC's. You might say to yourself, "these institutions have never been adequately supported, but they have survived," or you might say, "we have always been able to do more with less." Have such thoughts absolved you of doing something, of contributing to your alma mater? Are you aware of the fact that over 50 percent of all Blacks who earn the Ph.D. obtained their bachelor degrees at Black colleges? If some of these colleges are threatened, we must find ways to preserve them and the roles they fulfill. More than one million Black students were enrolled in U.S. colleges and unversities in the fall of 1980, and slightly more than half of these students attended colleges in the southern and border states. Of those enrolled in the southern and border states, over one-third were in IHE's where Blacks were the majority racial group of the student body. The 200,000 students in HBC's are almost always categorized as socially, economically and culturally disadvantaged persons who selected to attend the HBC's because they were unable to gain entrance to predominantly White IHE's because of low SAT or ACT scores. (Needless to say, low test scores are not deterrents if the applicant can dribble a basketball full court and can score or can run an 80 yard touchdown). But such characterizations do not fully describe HBC student bodies, because there are a number of able Black students, some of whom come from middle class homes which have made an HBC their first choice. There are Black families which have instilled quality of academic excellence along with the desire to preserve Black institutions which have assisted their children in selecting an HBC. You may recall former Atlanta Mayor Maynard Jackson saying that he began singing the Morehouse Hymn to his son as soon as he as born. And, a top official in the predominantly Black higher education association told her son who is graduating this spring, "You have over 100 historically and predominantly Black colleges from which to choose."

We all want to be a part of something great and wonderful but we must be about the business of preserving and enhancing these institutions which are repositories of Afro-American cultural heritage, which provide an atmosphere conducive to the development of a positive cultural identity and high regard for one's academic ability, and where students can feel totally free to excel and participate in any student activity, without any concern for its racial implications.

Now, I am not a segregationist. I believe in integration and there are some predominantly White IHE's where a Black student may matriculate and exit with relatively few psychological scars but know little of his/her role in American society. You see, it is felt that Newsweek magazine fired Sam Yette not because he wasn't a good journalist, but because he wrote The Choice, which exposed what was happening to Blacks in the highest policy-making circles. Howard University hired him. It is the HBC's which have picked up Black writers, musicians, social workers, sociologists, political analysts and others found to be too "radical" by majority institutions. And now with DNA research and all the new scientific technologies being developed, it is more important than ever that someone sensitive to the underprivileged keep watch to see where "they get the spare parts." Such sensitivity is generally more available in those settings where close contact with the socioeconomically disadvantaged is an every day experience and not a happenstance.

Edward Brown, writing in the August/September 1979 issue of The Black Collegian states, "The most important qualities for a person interested in becoming a health care provider to possess are an interest in the scientific and social aspects of well-being, a willingness to work hard and diligently, an awareness of human needs, and a sincere desire to perform a significant service for others." He goes on to state that "the allied health professions are all representative of the dual concerns of modern health care: the employment of technological resources, and the emphasis is on personal, total patient care." Blacks are seriously underrepresented in the allied health professions. About one-fourth of the HBC's offer one or more allied health programs. The members of the National Society of Allied Health could do much to remove the real and perceived barriers to Blacks in entering these fields by serving as role models to elementary and high school students, looking into the institutional practices and policies governing recruitment and admission, spreading the word on available financial assistance, and assisting in the development of adequate tutorial programs.

I would be remiss if I did not point out the excellent work you have done in trying to increase the number of minority allied health personnel and note the research performed by Doctors Harley Flack and Everlena Holmes. I'm certain that others of you have contributed to the field also but these two persons have worked closest with my office in Washington and therefore are known to me.

In summary, if there were no HBC's there would be fewer Black college graduates, fewer Black professionals, a smaller Black middle class, and fewer self-sustaining, taxpaying Black citizens. There would be fewer opportunities for Black students, faculty and adminstrators to grow and develop in an environment free of race and class prejudice. There would be fewer opportunities for Black Americans to develop a sense of self-worth and pride in the accomplishements of their own racial group, and to experience the common sharing of their heritage.

But most importantly - if there were no Black colleges, there would be a significant diminution of the opportunities for Blacks to acquire a realistic assessment of how far they have come while gaining the knowledge of how far they can and must go to obtain the wherewithal to become truly emancipated.

As a group, the HBC's enrich the nation. They are truly a National Treasure!

"TRADITIONALLY BLACK INSTITUTIONS OF HIGHER EDUCATION: THE MISSION, ROLE AND FUNCTION FROM A SOCIETAL PERSPECTIVE"

Raymond Wynn
President
Student Council
College of Allied Health Sciences
Howard University

Good morning educators, adminstrators, clinicians, fellow students, and friends of the National Society of Allied Health.

Being charged as a future leader in allied health, I first thank Dr. Flack and the other program coordinators for giving me an opportunity to address you, and for giving students a chance to participate in the conference. I am sorry to say that I'm disappointed that I don't see more of my fellow students from the various institutions that are participating. As stated yesterday, I believe that for every institution represented here at this conference there should be at least one student representative. Without student representation and participation, my thought is that this organization would be jeopardizing its future existence. To perpetuate and vindicate the existence of the National Society of Allied Health, I would again recommend that each institution emphasize the representation and participation of students in the meetings to come.

You know, it seems to me that lately that wherever I go or whatever I'm doing, I'm representing a minority. Even today, being one of the few students here, that as I look around, there seems to be more women than men here, and the same holds true for the College of Allied Health Sciences at Howard. So here again, I am a minority.

But in a more serious light, I'm going to talk about being a minority in the sense that we all know of being Black, and furthermore being in a Traditionally Black Institution of Higher Learning, I believe that the mission of these institutions should be to provide a quality and high caliber education to Blacks and other minorities that are less fortunate with issues dealing with socioeconomic status, or poor educational background, and to provide a place of cultural enrichment for those who seek it.

As far as role and function, I feel as though I would be rendering you and myself a disservice if I did not express to you first what I expressed to the National Council of Black Mayors on November 7, and secondly what I conveyed to the Mid-Atlantic Region's Society of Allied Health Professions.

To begin, I would like to remark on the health status of Blacks in America, emphasizing the importance of urban and rural Blacks becoming more aware of their health status. How aware are they? As quoted from Medical Care for American People, "It is well-known however, that 10% of our population who are colored have health problems that are on the whole, considerably more serious than those of Whites. The Negro is America's principal marginal worker and he suffers in the North as well as in the South from the many disabilities that this entails:- poorer housing, less adequate diet, less stationary surroundings, more employment of married women, and greater economic insecurity. The extensive migrations of Negroes during the last 20 years have added new complications to their problems. Although Negroes have lower death rate than Whites for a few diseases, rates double or more than double the rates of Whites that are recorded for tuberculosis, organic heart disease, acute and chronic nephritis, cerebral hemorrhage, pneumonia, typhoid fever, whooping cough, bronchitis, influenza, malaria, and pellagra. Not only is the death rate higher, but so is the incidence of illness at least for certain diseases." This was written, believe it or not, in 1932; but I'm sure many of you agree with me that some of this still holds true today! Our role and the role of the TBI's is to develop Black educators, adminstrators, clinicians, legislators, county officials, and leaders who can bring urban and rural Blacks a better awareness of their health status.

In addition, I feel we should become more aware of cancer. I say this because being a RTT student my primary concern is the cancer patient, and having been trained in a predominantly Black hospital such as Howard University Hospital, I can directly relate to the fears and myths that many Blacks have about cancer and the methods of treatment. Although analysis will probably show that there is a direct relationship between the incidence of cancer, hypertension, and heart disease with the quality of education, the types of jobs and level of political awareness of Black people. The number of Black elected officials a TBI can produce and put in office can help determine the quality of education of our people. "An educated person is aware, an ignorant person is blind."

The number of Black elected officials in office from TBI's, such as Andrew Young, can affect the availability of the types of jobs for Blacks which directly correlates with the health of the Black family because if there is no steady source of income the health of the family is comprised. In order to get Blacks in office the role of the TBI should be to promote voter registration and hold voter registration drives on campus as well as in the Black community.

Lastly, I say that we should strive to develop not just "typical" students, referring to those who have a one-track mind, either study or party. We want to develop "well-rounded" students - those who can make the Dean's list, those who can be more than competent clinicians, those who can rise above a social hermit because of the pressures of his or her curriculum. It is incumbent that as allied health professionals, the very backbone of most health institutions develop "more than competent and well-rounded students."

Again, I would like to thank the National Society of Allied Health coordinators and Dr. Flack for this opportunity, and extend a challenge to all institutions participating to have students here next year, and increase student membership and participation. I heard someone say yesterday, we came a long way baby... I'd like to leave with the words of Dr. Thurman E. Evans, "Ready or not, America, here we come!"

NETWORKING THROUGH LINKAGES: THE BENEFIT OF SHARING RESOURCES--MODEL ALLIED HEALTH PROGRAM FOR THE DEVELOPING OF MINORITY INSTITUTIONS

ON BEING AND BECOMING OF AGE -- A BENEFIT OF SHARING RESOURCES

Jacqueline Beck, Ed.D., Dean
School of Allied Health
Florida A & M University
Tallahassee, Florida

As always it is a pleasure for me to meet with the membership of the National Society of Allied Health. It is through meetings of this type that we, who share a common heritage, find renewal and stimulation. Each of us needs the endorsement and support of significant others and each needs to know that united we stand and divided we shall surely fall! I have been asked to share with you what, on the surface, might seem, at this point, a personal success. However, let me make it perfectly clear that whatever sucess I might appear to have achieved is merely evidence of the collective endeavors of many of you who made up this group. Our being and becoming of age in allied health is a direct result of the privilege of sharing. It is therefore my charge to each of us, and certainly to the group's leadership to keep this Society alive for all of us!

Florida Agricultural and Mechanical University confirmed, early in its history, its commitment to contribute significantly to improving the health status of disadvantaged citizens of Florida. Sensitivity to the need and demand for competent health care delivery resulted in the establishment of pre-professional educational pathways in medicine, dentistry, osteopathy, and veterinary medicine and, in 1909, a School of Nursing. By 1952 a School of Pharmacy was added to the existing health education options. The formation of a School of Allied Health Sciences, in 1982, brought a new dimension to the University's offerings and expanded its health science career opportunities.

The title of this presentation, "On Being and Becoming of Age -- A Benefit of Sharing Resources," was selected for several reasons. I believe that (1) the fact that FAMU perceived a School of Allied Health Sciences as something conceivable as existing or being, significantly influenced the direction and pace of its development; (2) the operationalization of the school with its complement of human and physical resources is testimony of its actual existence or being; and (3) the school must continue to experience change and experience the processes necessary to achieve the "goodness of fit" essential of "Becoming of Age" in the allied health education arena.

Like many of you, Florida A & M University expressed an interest in making allied health careers accessible to its constituents in the late sixties and early seventies. Proposals were submitted to the Florida Board of Regents (BOR) for a group of programs and to retrain existing faculty in selected major areas. Planning authorization was granted at that time but the needed support was denied. The request process was repeated in 1977. State approval of the four programs that make up our School was an integral part of the State University System's 1978 Revised Plan for Equalizing Educational Opportunity In Public Higher Education in Florida. Among the actions taken by the Board was the authorization for the University to plan and implement baccalaureate degree programs in physical therapy, medical records administration, respiratory therapy, and health care management. The timeframe for full implementation was designated as the 1982-83 accademic year.

The aim of the presentation is to share with you selected experiences that have significance for the theme of this conference. I shall attempt to organize this discussion into three phases: The pre-planning; planning; the implementation phases of development. In addition, the objectives, the selected processes involved in each phase and the expected outcome will provide an ongoing evaluaton of a formative nature.

For this discussion the periods will be distinguished as: The pre-planning phase which occurred between 1978-1980; the planning phase 1980-1982; the implementation phase 1982-1984.

The Pre-Planning Phase

Please understand that this phase is identified as one of significance since it preceded the granting of support by the Board of Regents. This was the phase of the theoretical--the phase of philosophizing--the phase when all things seemed possible. Goals, really problems, recognized during this phase were:

1. To obtain qualified faculty from an apparent scarce supply of personnel trained for instruction in allied health disciplines.

2. To recruit students from diverse backgrounds who are qualifed or who demonstrate potential for success in allied health professions.

3. To develop quality educational programs commensurate with the needs of a heterogenous learner population and the requirements of the selected allied health professions.

4. To identify and utilize clinical resources to the extent that it complements the desired educational ends.

The pre-planning phase was enhanced by the University's receipt of a Title III AIDP award and our selection as a participant in the AHSCU Minority Allied Health Project.

Through these sources, the following was achieved:

1. Initial contact was made with appropriate professional organizations. FAMU's intent to develop the selected professional program was made known and guidance from the agency requested.

2. Consultants recommended by the accrediting agencies and/or the AASCU staff were utilized to assist in the interpretation of "standards" and "essentials" of accredited programs. The same guidelines were employed in the planning phase.

3. A hidden agenda as established. One of the greatest benefits of participation in the AASCU project was it afforded this opportunity. It was primarily, through this medium, that a prized relationship between the representative of the "new program on the block" and veterans of the Crimean and other wars was established, existing networks were expanded, and many more profited from the experiences of a few.

FAMU was able to move into the planning phase with clearer preception of the problems inherent in the goals identified above. FAMU's hidden agenda was a checkpoint, a monitoring system that critiqued every morsel of advice advanced by those who made up the overt agenda--A benefit of networking!

Planning Phase

The planning phase can be defined in several ways. Officially, in our State University System, one is authorized by the BOR to plan a program. FAMU was authorized to plan in 1978. For this discussion, the period between 1980-1982 is identified as the planning phase.

The major objective for this phase was to operationalize a School for Allied Health Sciences to include a Division in Physical Therapy, Medical Records Administration, Respiratory Therapy, and Health Care Management by 1982. The achievement of this objective required the following:

1. The submission of implementation proposals to the Board of Regents for each program. The proposals contained results of feasibility studies or need assessments, justification of program location, complete curricula, including course outlines, faculty and enrollment projections for five years, and a categorical budget covering the same period.

2. Proposing an organizational structure for the School facilitating the School's autonomy, both acceptable to the administration.

3. Obtaining funds for implementation of programs.

4. Securing space to house the programs.

5. Recruiting faculty and students.

Funds supportive of this phase were provided by the BOR through earmarked "start-up" funds and designated AIDP dollars. The search for program directors spanned fourteen months. Position notices were placed in appropriate professional journals and circulated to universities all over the country. Searches were also conducted on site, at professional meetings. It was indeed an achievement to identify qualified applicants to fill positions of Director of Physical Therapy and Medical Records Administrator by August, 1981.

Networking was essential to this phase. Both directors were identified through this process. Meetings were held daily at least and the "hidden agenda" swelled to capacity.

At the same time, the Legislature allocated funds for a new facility to house the Schools of Allied Health Sciences and Nursing. Prior to this action, a building program was submitted. A narrative requisition and justification of space and equipment needs was submitted to the Legislature. Again the network served as a sounding and evaluative board, providing requested assistance throughout each phase.

Efforts to facilitate the entry of students into the programs began in this phase. Pre-professional requirements were announced in University publications and brochures were developed and disseminated. The support group readily shared materials used in their institutions to serve as a guide for the developing programs at FAMU. At the close of this phase, 1982, the School of Allied Health Sciences had been operationalized into four academic divisions. The Division of Physical Therapy was implemented with a Director and four faculty. The Division of Medical Record Administration began with a Director and Clinical Coordinator. The School was officially operational.

The Medical Record Administration Program received favorable recommendation by accreditation visitors in November, 1983 and the Physical Therapy Program received laudible acclaim by their team in March, 1984.

Unresolved problems areas are as follow:

1. Making the programs that we offer more accessible to Blacks.

2. Identifying Black models for faculty positions and in clinical settings.

3. Identifying Black students with the interest, potential and motivation to succeed in allied fields.

4. Assisting Black students to overcome deficits associated with a life experience that is different from that in the world of work.

5. Stimulating allied health faculty to function in a university community as peers.

6. Dealing with the whole process of clinical education.

These are but a few of the continuing unresolved problems that we have identified. I believe that we can continue to face the adversity of our times only if we do it together. Sharing seems the plausible solution.

LINKAGES AND AFFILIATIONS

Andrew Bond, Ph.D., Dean
School of Allied Health Professions
Tennessee State University
Nashville, Tennessee

INTRODUCTION

The primary aim of this discussion is to share information on cooperative arrangements between Tennessee State University (TSU), a public land-grant university, and Meharry Medical College (MMC), a private health care training center with a medical school, dental school and a teaching hospital. The origin of the idea for cooperation between these two institutions is not known. However, the original covering agreement which delineated the reasons for cooperatively offering allied health education programs clearly indicated that top administrators at both institutions expected returns not available in the absence of cooperative activities. Top administrators of TSU envisioned the following accruals to their institution:

1. The ability to offer needed allied health programs that would be too costly to implement alone.

2. Strengthening its faculty through close association with their peers at a major medical college.

Top administrators at MMC envisioned the following accruals to their institution:

1. Decrease the cost of programs currently offered and increase the enrollment of these programs.

2. Expanded program offerings to train practitioners needed to operate their own facilities.

It was generaly anticipated by these administrators at both institutions that TSU would provide the general education courses and MMC would provide the "clinical" (major field) courses.

It was decided to call this jointly administered and supported activity the Center for Allied Health Professions. A director was appointed, and the slow and tedious process of building confidence and support of this activity by faculty and second level administrators of the two institutions got underway. In this case, neither of the institutions' informal structures were supportive of the cooperative arrangements agreed to by the institutional admininstrators. However, over the years, all aspects of this relationship have improved. The overt negativeness on both sides by the faculty and second level administrations has almost vanished. Occasionally, benign neglect crops up as a problem.

MODELS FOR COOPERATION

Under the terms of a covering agreement, TSU and MMC now operate a School of Allied Health Professions. The terms and conditions of this agreement, as they relate to faculty appointments and enrollment of the students, are shown in Attachment I. The individual programs under the auspices of this school operate under separate agreements for the respective six programs.

The terms and conditions for the operation of the dental hygiene program are shown in Attachment II. These terms and conditions for dental hygiene, for example, are based upon the history of the program and available resources at the two institutions. No effort has been made to equally divide the total cost of this program between the two institutions.

The terms and conditions for the medical technology program are very similar to the ones for dental hygiene. However, for this program as an example, there is one significant exception, the two institutions have made an effort to share equally in cost for program maintenance and operation.

To date, there are no written agreements for the operation of the other programs. These programs have affiliation agreements with MMC's teaching hospitals.

This is obviously a unique situation in that TSU and MMC are both historically Black institutions located in the same metropolitan area. However, since most historically Black colleges are located in cities with hospitals, potentials for similar types of cooperation exists between these institutions. The proposition is to find areas of individual and collective benefits. A number of hospitals operate their own training programs, such as medical technology, radiological technology, respiratory therapy, stenography, etc. It is possible that some of these hospitals may be receptive to proposals for cooperative arrangements in which support is provided above the level of usual clinical affiliation arrangements.

ATTACHMENT I

AGREEMENT

Between

TENNESSEE STATE UNIVERSITY

and

MEHARRY MEDICAL COLLEGE

WHEREAS, TENNESSEE STATE UNIVERSITY (TSU) AND MEHARRY MEDICAL COLLEGE (MMC) the parties of this agreement entered into an agreement dated April 12, 1971, which provided that said parties would cooperate in the offering of joint programs in the Allied Health Professions;

WHEREAS, a Center was established by agreement between the two parties on April 21, 1971, and a director was appointed to assume responsibility for overall leadership, direction and operation of the Allied Health Center;

WHEREAS, the Center of Allied Health was elevated to School status and a Dean appointed to this School to assume the responsibility formally assigned to the director of the Center; and

WHEREAS, it is the desire of TSU and MMC to continue the joint programs in Allied Health under a revised and updated agreement for these programs; under the auspices of the joint School of Allied Health Professions, subject to the terms of this agreement;

PREMISES CONSIDERED, AND FOR AND IN CONSIDERATION OF THE MUTUAL PROMISES, COVENANTS AND OTHER GOOD AND VALUABLE CONSIDERATION SET FORTH BELOW, THE PARTIES HEREBY AGREE AS FOLLOWS:

General Terms and Conditions:

1. Students will be admitted to jointly operated programs in the allied health professions according to admission regulations agreed to by the two institutions.
2. Students will enroll in and pay all fees at TSU. Special fees, if any, will be decided upon jointly each year by TSU and MMC. When MMC provides service or material and special fees are collected, an amount equal to these fees will be transmitted to MMC by TSU.

3. Students enrolled in these program will have the same rights and privileges as other students at TSU and MMC.

4. Upon completion of the prescribed courses, students will receive either the Associate of Arts degree or the Bachelor of Science degree from TSU and a certificate in the specialties from MMC.

5. All faculty members employed to teach in the jointly operated programs will have the same rights and privileges as other faculty members at TSU and MMC, except for compensation, tenure and academic rank. Faculty members will be compensated, awarded academic tenure and rank according to the regulations of the institution of primary employment.

6. The responsibilities of TSU and MMC individually and jointly for the operation of the Dean's office and the respective programs currently in existence, and those developed in the future, shall be delineated in separate components of this agreement.

7. The Vice President for Business Affairs at TSU will assume responsibility for computing the amounts of money due each institution and remit to the Vice President for Finance and Business at MMC the amount due, or a bill for the amount due TSU by May 31, each year.

I. DEAN'S OFFICE

A. TSU agrees to the following responsibilities:

1. Salary and fringe benefits for the Dean of the School of Allied Health Professions.

2. Space, supplies, equipment, local and long distance communications, travel, printing and binding, dues and subscriptions, as needed for the operation of the Dean's office.

3. One Secretary III.

B. MMC agrees to the following responsibilities:

1. Remit fifty percent (50%) of the salary and fringe benefits for the Dean to TSU.

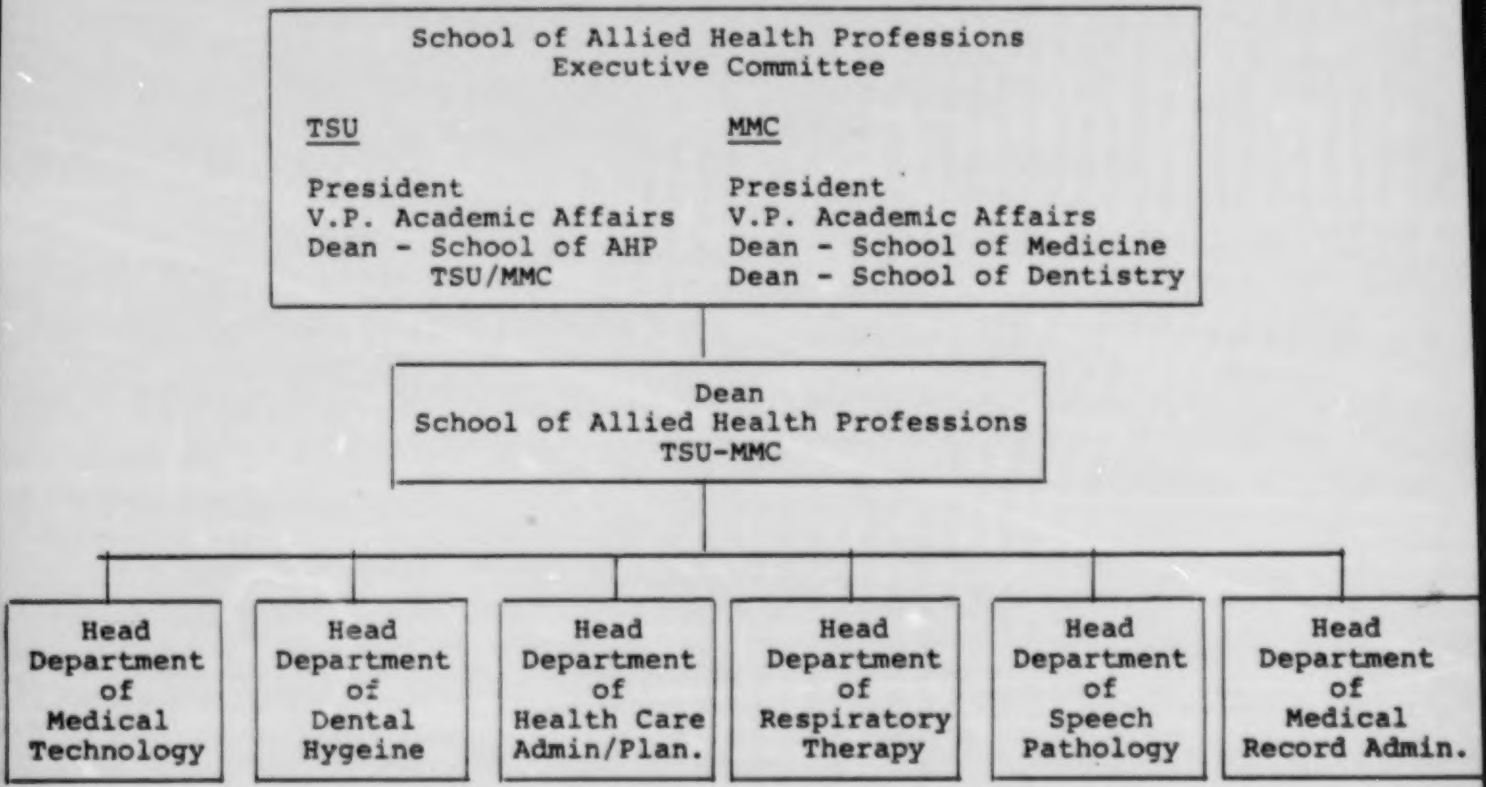
C. TSU and MMC agree to the following responsibilities:

1. The Dean of the School of Allied Health Professions shall be jointly appointed by TSU and MMC.

2. The Dean will have the same rights, privileges and authority as other deans at TSU and MMC.

SCHOOL OF ALLIED HEALTH PROFESSIONS

ORGANIZATIONAL STRUCTURE


School of Allied Health Professions Executive Committee
TSU
President
V.P. Academic Affairs
Dean - School of AHP TSU/MMC
MMC
President
V.P. Academic Affairs
Dean - School of Medicine
Dean - School of Dentistry
Dean School of Allied Health Professions TSU-MMC
Head Department of Medical Technology
Head Department of Dental Hygeine
Head Department of Health Care Admin/Plan.
Head Department of Respiratory Therapy
Head Department of Speech Pathology
Head Department of Medical Record Admin.

ATTACHMENT II

II. DENTAL HYGIENE PROGRAM

A. Tennessee State University agrees to the following responsibilities:

1. Instruction in general education and basic science courses. This provision does not require Tennessee State University to add to the Arts and Sciences faculty but does allow for special sections for dental hygiene students in general education courses and for special content in designated sections to basic science courses.

2. Remission of 50% of tuition and fee payments to the Vice President for Business and Finance at Meharry Medical College.

3. Salaries for two full-time dental hygiene faculty members and two full-time support personnel--one clerical and one clinical assistant. This provision allows for the addition of added personnel should the dental hygiene enrollment significantly increase such as to require appropriate faculty to student ratios in accordance with accreditation standards.

4. Maintenance and operation of the dental hygiene program and facility including support for instructional and movable equipment, instructional and office supplies, printing and binding, maintenance and repair services, local and long distance telephone services and postage.

B. Meharry Medical College agrees to the following responsibilities:

1. Salaries for five full-time equivalent dental hygiene faculty personnel, one full-time secretary, one 0.5 equivalent faculty person to serve as dentist-supervisor and one 0.6 full-time equivalent dentist for instruction in dental sciences.

2. Clinical rotations within the School of Dentistry for dental hygiene students and opportunities for these students to be taught within classrooms and laboratories within the School of Dentistry.

3. Opportunities for dental hygiene faculty personnel to participate in the dental practice plan of the School of Dentistry.

4. Opportunities for dental hygiene faculty personnel to audit dental courses, fee exempt, for purposes of faculty growth and development.

5. Opportunities for dental and dental hygiene students to establish professional working relations so as to eliminate gaps between services to patients.

C. Both parties, Meharry Medical College and Tennessee State University, agree to the following joint responsibilities:

1. To afford adjunct faculty status within the School of Dentistry to dental hygiene faculty personnel.

2. Dental hygiene faculty persons will provide instruction to dental students at the level of 0.1 full-time equivalency.

3. For the year 1984-1987, should funds from grant sources be available, 30 percent of the salary of an assistant professor of dental hygiene will be remitted to Meharry Medical College.

A MODEL JOINT DEGREE ALLIED HEALTH PROGRAM FOR DEVELOPING MINORITY INSTITUTIONS

By
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School of Allied Health Professions/
Grambling State University
College of Science and Technology
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INTRODUCTION

Social, economic and political trends over the past decade have dramatically accentuated the financial problems of developing predominantly minority institutions' Allied Health Programs. In stark contrast to the period of prosperity and program expansion, Allied Health Programs and schools of Allied Health today are faced with the task of program expansion and development in an atmosphere of declining enrollments and declining federal/state funding.[1] Minority institutions and administrators, at the same time, are faced with the reality that their institutions must expand program offerings in the relatively new Allied Health Professions if they are to remain attractive to potential students.[2] Administrators of predominantly minority institutions are having to garner resources to enter the market for allied health training funds in the face of this adversity.

The administrative model presented in this paper describes state and/or regional Allied Health preclinical and clinical training centers wherein predominantly minority institutions may attract students to the Allied Health Professions by articulating with accredited Allied Health Programs in majority institutions. This joint degree model allied health program utilizes the science faculty and resources available at the predominantly minority institutions as well as faculty and staff from the majority institutions.

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[1] Anderson, P.W., Nunn, R.S., and Sedlacek, W.E. Collegiate Programs in Allied Health Occupations: Program Cost and Financial Aid. Washington,D.C., American Society of Allied Health Professions, 1977.

[2] Katz, Elaine F. "Articulation: A Concept Supporting Alliance in Education," Journal of Allied Health, May 1983, Volume 12 (2), pp. 133-140.

The joint degree model which links minority and majority institutions utilizes the concept of inter-institutional articulation. Katz noted that articulation offers a tested base and a supporting theoretical framework from which collaborative, cooperative and coordinated activities can be rationally planned and implemented.[3] The majority and minority institutions collaborate on the following activities: course credit; transfer; curriculum design; resource sharing; academic support and student financial aid counseling. The inter-institutional joint degree program contains four major conponents with interlocking relationships between faculty, staff and administrations. The components are recruitment, comprehensive counseling, support (preclinical and clinical phases), admissions and career placement.

MATRICULATION

Applicants from the predominantly minority institutions and accredited high schools are recruited into a joint degree Allied Health Program. The preclinical courses of Physical Therapy, Occupational Therapy, Rehabiitation Counseling, Medical Technology, Cytotechnology and Cardiopulmonary Science curricula are combinations of general education requirements, chemistry and biological sciences. These course are pursued in the campuses of the predominantly minority institutions. Following successful completion of the preclinical segment of the program, students apply for admission to the clinical phase of training on the campus of the established institutions. Students, upon successful completion of the clinical phase of the program, are awarded the undergraduate diploma jointly by the majority and minority institutions.

ADMINISTRATIVE ORGANIZATION

The respective administrative officers of the minority institutions (Deans), in collaboration with the established School of Allied Health, initially form an adminstrative task force whose expressed purpose is to develop all policies and procedures for the joint degree programs in the Allied Health disciplines. This task force evaluates the adequacy of the preclinical resources available at the developing minority institutions. This council of administrators develops an annual implementation plan for the entire project.

The Joint Degree Model provides for a coordinator of joint degree activities who is directly responsible to the Dean at the established institution. The joint degree coordinator along with

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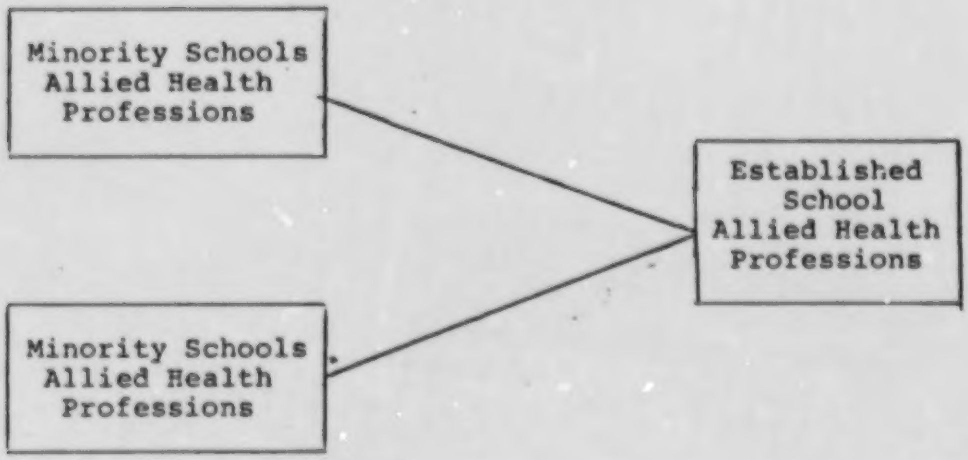
[3] Katz, Elaine F. "Articulation: A Concept Supporting Alliances in Education", Journal of Allied Health, May 1983, Volume 12 (2), pp. 133-140.

JOINT BACCALAUREATE ALLIED HEALTH PROFESSIONS PROGRAM


Minority Schools Allied Health Professions
Minority Schools Allied Health Professions
Established School Allied Health Professions

a staff of counselors are responsible for recruiting and providing the comprehensive support system through both the preclinical and clinical phases of the program. The counselors are located on the campuses of the minority institutions and have faculty status at both institutions.

ANNUAL IMPLEMENTATION PLAN (AIP)

The annual implementation plan is a one-year inter-institutional action plan which contains program priority objectives developed by the Deans of the established school and each of the participating minority institutions. Budgets for participating institutions are developed based on considerations outlined in the AIP. Implementation of the AIP actions is the responsibility of the Deans and joint degree program coordinator. The AIP establishes a policy of cooperative planning and implementation of program activities.

AREA OF RESPONSIBILITY

All academic and professional allied health educational policies are primarily determined by requirements for professional accreditation in each of the several Allied Health Programs. Subsequently, pre-professional requirements, admissions policies, professional curricula, student selection and programmatic policies are as stated in the established School of Allied Health catalogue. This policy of adapting the established school's curriculum and retention standards assures continuity in educational policy and conformity to certification requirements for participating institutions.

Deans from the minority institutions are responsible for management of funds allocated for preclinical activities but exercise no direct control over funds expended by the established institutions. Budgetary support for the coordinator and the counselors is vested with the Dean of the established School of Allied Health.

DISCUSSION

The Joint Degree Model for Allied Health Education attempts to address some of the problems associated with limited funding and the shortage of trained faculty in the Allied Health Professions. The thrust for this program follows the recommendations from the National Commission of Allied Health.[4] The implementaton of this model on the context of a desegregation of higher education order has received mixed reviews from students, faculty and administrators in both the minority institutions and the established majority institutions.

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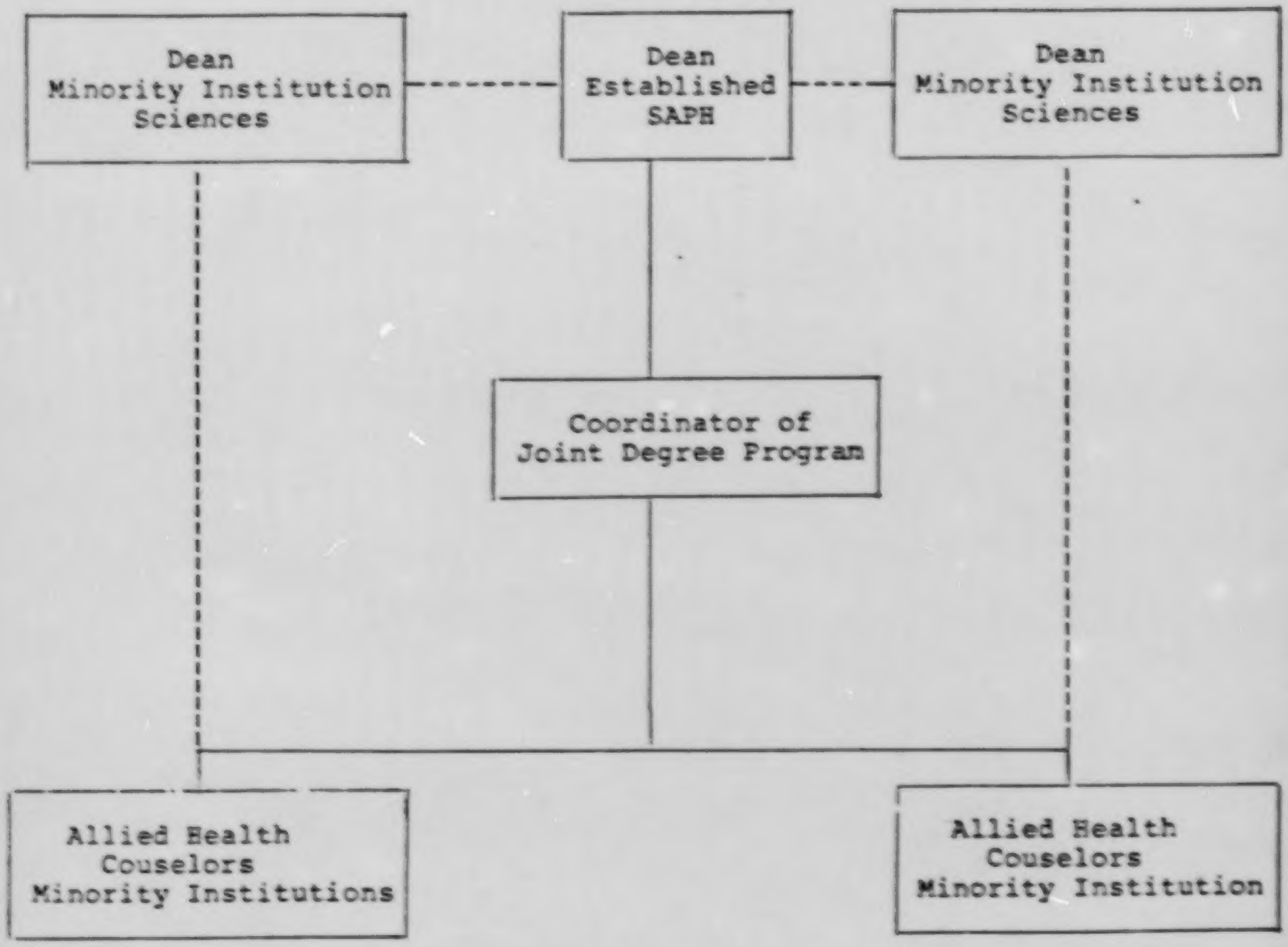
[4] National Commission on Allied Health Education: The Future of Allied Health Education, San Francisco, Jossey-Bass, Inc., 1980.

JOINT DEGREE ALLIED HEALTH PROGRAM

ADMINISTRATIVE ORGANIZATION


Dean
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The predominantly minority institutions consistenly raise the questions centered around the argument of institutional enhancement and latent fears of losing their institutional identity. It has been asserted by national leaders in allied health that the minority institutions are not receiving an equitable share of enhancement funds under this model. It should be noted that expansion of existing clinical facilities is achieved by increasing funding at the clinical sites while at the same time, new faculty and basic science facilities are enhanced at the minority institutions. This model which utilizes voluntary coordination inadvertently seeks to maintain the status quo. McDermott et al., reports on a similar program which used voluntary coordination in Dallas, Texas which produced favorable results according to the high school and community college participants who interfaced with the established university Allied Health Programs.[5]

The majority institutions in their view of this model are forced to give up some of their autonomy in student selection and retention. The established institution is also under the general guidance of a state or federal compliance monitoring committee. While the joint degree Allied Health Model in its current form requires a number of accommodations on the part of all participating institutions, this model allows for introduction of Allied Health courses on the campuses of the minority institutions at a minimum cost. The joint degree concept secondarily produces alumni with allegiance to the minority institutions and the established institutions.

An evaluation model for this cooperative effort has been planned for the coming year. Faculty, students and adminstrators await the outcome of an evaluation of this possible remedy to equal access to Allied Health Education for minority students who choose to attend predominantly minority institutions for the pre-clinical phase of allied health education.

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[5] McDermott, Robert J. and Peterson, John L. "Inter-institutional Cooperation in Allied Health Eduational Planning: A Case for Statewide Studies," Journal of Allied Health, May 1981, Volume 10 (2), pp.126-133.

NETWORKING: A METHOD OF ENHANCING PROGRAM OPERATION AND SURVIVAL

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INTRODUCTON

One of the newest members of the Allied Health Professions is the physician assistant, being approximately twenty years old (New York Times, 1984). Like all new programs, there have been trying times to test the program's survivability. The physician assistant programs can verify that they have been tried through funding cutbacks, problems in recruiting qualified faculty and program directors, student recruitment and retention, curricula designs, and other resources which adequately prepare students for the job market. Another area of concern for graduates and students has been in gaining acceptance from other health professionals and consumers. Faculty members of physician assistant programs are committed to the furtherance of the profession, but they may be limited by resources. Through sharing ideas, successes or failure, expertise and learning materials among programs, strategies may be realized to deal effectively with areas of concern. Such a process can be defined as networking, where a relationship exists between two or more interested parties for purposes of enhancing program operation and survival.

STATEMENT OF THE PROBLEM

Only three of the fifty-six physician assistant programs in the country are predominantly Black. Howard University and Charles Drew Postgraduate Medical Physician Assistant programs have graduated approximately fifty percent of all Black physician assistants in the country. It is of interest to note that Blacks represent approximately 3.3 percent of 15,000 physician assistant graduates in the country (AAPA survey, 1981). Program survivability is therefore a high priority for Howard and Drew to ensure adequate minority representation in the profession. Through a networking process, these two programs can determine areas of strengths and weaknesses, identify means of strengthening deficient areas, enhance faculty and director development, develop mechanisms to facilitate student entry and retention, and to outline future plans for cooperative efforts among the two facilities by adding to the literature through research and publication.

RESEARCH QUESTIONS

1. What are the strengths and weaknesses of the Howard and Drew Programs?
2. What mechanisms can be used to strengthen areas of weaknesses of each program?
3. What are the mechanisms used for faculty and director development, and how were they determined?
4. What areas of faculty and director development are needed to enhance the program's operation?
5. What is the current admission and retention criteria of students being used by each program?
6. What is the attrition rate of each program?
7. What can be done to facilitate entry and retention of students in each program?
8. How many graduates are employed as PA's?
9. How many graduates have passed the National Certifying Examination?
10. What is the activity of research and publication among the faculties of each program and what is the area of interest?

METHODOLOGY

The networking process between Howard and Drew Physician Assistant programs will be divided into five phases. The first phase will begin in the summer of 1984. The study is expected to be completed by the summer of 1985.

Phase I. Faculty and program director exchange, where faculty members who are responsible for curricula design and clinical coordination will be involved in the study.

The objectives for the faculty member exchange will include:

1. To review admission and retention criteria of each program and determine if it is a useful predictor for students successfully completing the program.
2. To review the curricular designs and course evaluations used by the programs, and make recommendations for curricula that offer the maximum flexibility for students who have difficulty in academic performance.

3. To tour clinical facilities and meet with administrators and personnel who are involved in the education process of students and make recommendations to maximize the clinical application of knowledge.

4. To share job descriptions and responsibilities of faculty members and make recommendations for maximuim utilization of faculty skills and expertise.

5. To provide information on internal and external resources which offer support to the programs, and determine how to appropriately utilize resources in providing quality education that would be most cost effective.

The objectives for program directors will include:

1. To share areas of responsibilities and other activities, and make recommendations for development that would enhance leadership abilities.

2. To provide information on the involvement with the alumni, clinical faculty, and medical community, and make recommendations for activities that would serve to enhance program visibility and to maximize the utilization of resources that these groups can offer.

Phase I will occur during the summer and fall of 1984.

Phase II. Planning session with the faculties of both programs will be conducted to discuss the findings of the exchange and make recommendations for program development. A suggested mode of operation to improve program operation will be presented. This activity will occur at the mid-year meeting of Physician Assistant Programs in November, 1984.

Phase III. Implement the plan. This will occur during November, 1984 to April, 1985, as a follow-up of the mid-year meeting. A written report in the form of a log will be kept by each program, reflecting the activities recommended for program operation. Telephone calls will be made on a periodic basis as needed for clarification purposes.

Phase IV. Evaluate the process. This will be done at the Annual Meeting for the Physician Assistant Programs during April, 1985. A written report from each program will be discussed; the findings will be compiled in the form of a paper to be presented at the mid-year meeting of Physician Assistant Programs in November, 1985.

Phase V. In making recommendations for continued networking, the decision will be based on the findings of Phase IV.

DISCUSSION

The findings and implications are pending as this study will begin during the summer of 1984.

It is hoped that this networking relationship between Howard and Drew Physican Assistant programs will serve as a model to be considered by other allied health programs.

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2. Johnson, Sharon. "Paging Physician Assistants", New York Times. New York, 1984,

LUNCHEON ADDRESS

A SALUTE TO MINORITY ALLIED HEALTH LEADERSHIP IN THE '80's

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Division of Disadvantaged Assistance
Bureau of Health Professions, HRSA
Rockville, Maryland

I am delighted to have the opportunity to attend this meeting of the National Society of Allied Health and to give a few brief remarks on your theme, "Sharing: The Key to Networking." I bring you greetings from Dr. Robert Graham, Administrator, HRSA, and Mr. Thomas Hatch, Director, BHP, last but not least, from the greatest division of the PHS, DDA. Why are we great? -- Because we are combat tested.

I can easily relate to the theme of this important meeting and I am indeed interested and continue to be concerned about the need for cooperation between and among institutions engaged in the education and training of minority health manpower. Harley Flack's report - An Update of the 1980 Report - "Minorities in Allied Health Education" - includes a recommendation that "Minority institutions should develop networks to (1) link minority institutions offering pre-allied health programs with minority institutions offering professional level offerings, and (2) form linkages between minority institutions with professional level allied health programs. Through such linkages, faculty, staff, curricula, and other resources can be shared in cooperative strategies for improving minority student recruitment and retention activities in minority institutions." I would only add that item (2) be revised to include majority insitutions, also.

Since 1981, HCOP has directed support toward those efforts that would link services and institutions. We have also stressed the importance of educational pathways which depend upon linkage to be effective. In 1979, the Division of Disadvantaged Assistance, HRA, DHHS, contracted with the American Association of State Colleges and Universities (AASCU) to increase the number of minority students in allied health educational programs. Specifically, the project was charged with providing allied health technical assistance to a group of 23 selected senior-level colleges and universities (public and independent) having significant or predominate (generally 45 percent or greater) minority student enrollments. The contract ended August 31, 1983 at a cost of $1,165,922. During the project, eight of the 21 colleges and universities initiated 17 new baccalaureate-level allied health programs, representing a 77 percent increase.

Formal linkages were obtained by participating institutions for 25 allied health programs. Improvements occurred in three existing allied health programs: A cooperative 2+2 program in medical technology at UMES in place of the largely inactive 3:1 program, the securing of clnicial agreements and preclinical curricular modifications for the medical techology program at Virginia Union, and the closing of the physical therapy program at Tuskegee in order to strengthen for reopening as a masters degree program.

Of the 21 participating colleges and universities, 19 institutions either developed new allied health programs, improved existing programs and/or developed new linkages for allied health.

During the project, two consortia were formed: The "Alabama Consortium," comprised of Alabama A&M, Alabama State, Clark, Talladega and Tuskegee; and the "Hispanic Consortium," comprised of the four institutions having predominantly Hispanic student enrollments (Incarnate Word, Inter-American, Pan American and UTEP). Both consortia provided an opportunity to exchange information and views and to plan and develop joint programs and linkages. The consortia show signs of continuing for sometime in the future.

Ten of the participating institutions plan to implement 25 new allied health programs. In addition, the participating institutions plan linkages with 9 universities, representing new cooperative arrangements for approximately 50 allied health programs.

The estimated total number of students per year in new and improved allied health programs and linkages developed during the project is 419. The estimated total number of students enrolled in both new and previously existing allied health programs in the participating institutions is 749, representing a 127 percent increase in the number of students enrolled at the start of the project. As a result of the findings and activities of the project, the following recommendations were made:

1. It was strongly recommended that appropriate agencies in DHHS consider providing federal start-up funds for those efforts. As you know federal funding ended several years ago in this area.

2. It was also recommended that DDA consider sponsoring a 1-2 year effort to increase allied health activities at an additional 10-15 minority colleges and unversities.

3. It was recommended that such materials - including films and/or other AV materials, and also including those in Spanish - be developed with federal support.

4. It was recommended that a national commission be formed comprised of representatives of major allied health professional associations and others, as deemed appropriate. The commission should be charged with making specific recommendations for activities that could be undertaken by the association to increase the numbers of minority students and the visibility of minority practitioners.

5. It was strongly recommended that federal support by the appropriate agencies be considered for activities designed to provide financial support for Hispanic students and educational opportunities uniquely designed to meet their needs, as well as those Hispanic health care consumers.

6. It was strongly recommended that federal support by the appropriate agencies be considered for graduate study in the professional fields.

In the current grant cycle we are processing 259 applications requesting $118,667,571 over a three year period. The first year, FY '83', request is $37,939,440. Of the 259 applications, 21 are from allied health schools and 77 are from undergraduate institutions. As many as 50 percent of the latter applications are targeted to the allied health disciplines.

Allied health centers offering facilitating entry and retention programs were given a funding preference in this cycle. This, however, did not preclude any eligible entity from requesting support involving linkage between institutions engaged in education and training of minority allied health practitioners. I have read a few applications that have proposed to establish linkages to accomplish some the objectives of this conference. I am not optimistic that the current grant cycle will yield a significant number of linkages. Over the years the government has funded many institutions that should have been a part of a consortium or linked to a stronger program. It then becomes very difficult for these institutions to become a subcontract rather than a prime grantee. In other words, the need to maintain autonomy appears to be greater than the need to insure that students recruited into the program leave equipped to compete for jobs on an equal basis with graduates from other institutions.

Perhaps a discussion of "Sharing: The Key to Networking" should first define the word sharing. Sharing may be defined as contributing equally to most people. If that is the case, then cooperation becomes difficult if not impossible. Since institutions are people, successful networking must be effected by people -- us!

I am reminded of a point in my career nearly 14 years ago when I, armed with a Ph.D in Preventive Medicine and Public Health, was still teaching anatomy and physiology at Mississippi Valley State

College, Itta Bena, Mississippi; the Delta State College, Cleveland, Mississippi. The Tufts-Delta Health Center in Mound Bayou, Mississippi, was introducing a new concept of health care delivery to people who in many instances had never received any health care. I volunteered my services to the Center to at least gain some valuable experience in my professional discipline and help my people -- who, too often, are the tired, the poor, the huddled masses yearning to be free. This was still not becoming fully involved in the thing I had been trained to do and it took Andy James and John Hatch to recruit me to work in the health center -- and to push me to get involved in my discipline as Training Officer and Deputy Center Director. You see, I had been told so many times that I needed more experience and/or more education, that subconsciously I accepted it as a fact. Andy made sure I was given every opportunity to "catch up" experientially with those who had benefited from the traditional network. He not only did this for me, but for the entire center staff -- especially those employees who were not a part of any network. This was the beginning of my participation in an ever-expanding network that continues today and that you must become a part of now if you already are out in the work force and later if you are a student.

A classmate of mine at the University of Oklahoma -- the late Cornelius Askew (we made a vow in school that one of us would always have a job if the other worked, even though the only thing standing between both of us and the poor-house was a Southern Fellowship Grant), when interviewed by PHS in 1971 for a job recruiting epidemiologists -- painted such a glowing picture of my qualifications (I had no experience in the field at the time, but a lot of theory, and that's what OJT is all about in the other network) that I was hired within 90 days. For 12 years prior to that time, I had sought employment in the Federal government and had given up all hope -- since I was now convinced that I would always have too much training and too little relative experience or not the specific kind of training required and, therefore, no experience.

I was in government for only 15 months when Cliff Allen, who was in a position to recommend staff to the Administrator, asked me to consider a job which had the potential to do great things for the underserved and to participate in the Agency at the policy-making level. Here, again, I was being helped by a person, not in the traditional network, who was also offering to work with me as I "caught up." If you miss the boat after that kind of assistance, it is definitely your fault.

I am sure I'm not the only one who has received that kind of support, but I bet no one recognizes its importance more than I do. For that reason, it is not hard for me to:

- Keep a drawer full of resumes at my fingertips for those eventualities when the system affords me the opportunity to recommend someone, usually at the last minute and requires unique and scarce qualifications, i.e., Vivian Pinn;

- Be innovative in my hiring practice, i.e., creation of new jobs;
- Make time to provide advice, consultation, and encouragement to those seeking employment;
- Make time to provide advice, consultation, encouragement, and part-time employment opportunities to students;
- Do business with minority entrepreneurs who are looking for that opportunity to get their first contract and are without the "track record" that the system requires;
- To nominate and support someone else in the network even when the job pays more than mine, is of higher rank than mine and I can do it -- but the other person has a better chance of meeting the tailor-made criteria;
- To use the network not only when you need something but when you discover an opportunity that can help someone else.

I am in all kinds of networks. Some for years, others newly-formed. How do I know I am in a functioning network?

- From time to time, the same people contact me or I them and we help each other in tangible ways;
- People I have never met are referred to me by someone I know in the network and may assist me or I them;
- I found out much later that I have been afforded an opportunity because someone in the network recommended me and persisted.

How do I get in to a network of health workers?

- Have something to offer;
- Have an overriding desire to contribute more than you expect to receive even though your personal needs (employment, etc.) are paramount at the moment. Altruism.

Effective and long-lasting networks are not too large, yet extensive enough to indirectly positively impact upon the lives of many. Most of the networks I have been a part of are small because people are entering and leaving all of the time. People don't stay because high visibility does not make for an effective and efficient network operation especially, the kind of network you and I have in mind. You see, we need a network where there are no philosophers, kings, but soldiers and workers -- every strand is of equal importance in the fabric of things. Your greatest reward will be the satisfaction that you gain from being in the position to help others and -- doing it!

There is a network of minority health educators and professionals. For some of us, it is alive and well -- for others, it has never existed. We cannot make quality health care in America a birthright unless we participate. We need each other now more than ever.

If you have not seen it that way, I hope my remarks have given you pause for thought, and reflection, and will stimulate your interest and commitment to participate.

I know it still seems that the odds are stacked against us in many ways and, yet, at the same time, we recognize that so many people are depending on us to use our fourscore and ten to make things better not only for our posterity, but while we sojourn here.

In essence, my fellow workers: On this day, March 31, 1984, "The woods are still wide, still dark, and still deep, and we still have many promises to keep, and miles to go, before we sleep."

IMPROVING LEADERSHIP SKILLS AND PROFESSIONAL VISIBILITY: A MODEL FOR NETWORKING AMONG INSTITUTIONAL LEADERS AND EXTERNAL ORGANIZATIONS

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A recent television program, which presented a synopsis of one of the most well accepted theories on how the Egyptian pyramids were constructed reminded me of the model for networking which I shall share with you today. The pyramid construction theory suggests that blocks of stone were carved from a quarry, which is approximately 15 miles from the side of the Grand Pyramid. It was proved that the blocks could easily be cut with the primitive tools used thousands of years ago, and then dragged by thousands of men over the sandy terrain, 15 miles to the site of the pyramid and carefully stacked in a manner which permitted a central core of blocks, to be slowly raised until the peak was reached. The outside, slanted walls of the pyramid, were then added from the peak down to the base. This concept and the concept necessary to build with Legos, the blocks with which children and probably many adults design elaborate structures, are helpful ways to visualize the networking model which I wish to share with you. The completed pyramid represents the culmination of a career. Conceptually, the career is never completed in this model, for the model assumes life long learning. Each of the blocks represents a skill, or set of skills or knowledge, which when carefully added to fit the architectural design of the pyramid, result in the structure which, when only its base was complete, was visible only to those close by. As pieces are added toward its final form, it is visible for miles; therefore, to thousands. The same concept applies as career visibility is developed.

Before I begin to describe the career building blocks, let me define professional visibility. Professional visibility is the degree to which one's skills/talents are obvious to those who control the identification and dissemination of the names of highly qualified and talented persons. This includes persons who are judged to be particularly capable for special tasks, including developing innovative ideas, solving professional problems and communicating with major community or political agencies or persons. Visibility can be rated by the frequency with which one's name will be mentioned by those involved in the identification of such persons. This networking model has as its core, the requirement that if leadership is major career goal, efforts must be consciously and deliberately made to constantly improve visibility. This is not to suggest that other skills are not mandatory for success. The model does not ignore these; it assumes them. It assumes basic knowledge and professional expertise. But, it does not assume a direct relationship between these competencies and the professional community's awareness of them. Therefore, the premise upon which this model is built, is that networking among institutional leaders and external organizations should begin with attempts to improve visibility.

Our comment about basic skills, supports an assumption that the first level of the pyramid is firmly set. It is this base which represents basic professional knowledge and technical skills. Many other blocks needed to make the core of the pyramid are a part of the armamentarium of most professionals. They include communication ability, leadership skills, innovative skills, administrative skills, coordination skills, etc. These skills must be demonstrated within the organization and in the community, both the directly related agencies and those peripherally related to major responsibilities.

Three extremely effective techniques, which may be used to increase these skills and improve visibility, are: 1) planned informal exposure to other leaders; 2) planned participation in important organizational committees and other activities and, 3) planned community service. The best place to start is upon beginning a new position. The first set of blocks which one might use to improve visibility can be "cut" by creating opportunities to informally get to know the leaders of the organization, both those with whom one works directly and those with whom one will have professional contact, whether infrequent or frequent. A decision about who these persons are, can be made by carefully reviewing the organizational chart and discussing the various positions on that chart, with the immediate superior or first line colleagues who have been in the institution/agency for a year or more. It's often beneficial to start the informal sessions with immediate colleagues and branch out. These sessions may be coffee klatches; but one of the best settings is luncheon meetings with one person. The singular "person" is important. The involvement of more than one person, no matter how well acquainted with each other, can significantly reduce the effectiveness of the session. No emphasis of the importance of these sessions is adequate, for notwithstanding all the negative remarks, puns, jokes, etc., about the businessman's lunch, the rip off of the tax system, the long hours away from the office and other such comments, many of the major decisions which influence the functioning of most organizations are made, not when a formal meeting involving all of the principals are in attendance, but, at prior informal meetings. Networking for leadership is strongly related to this type of encounter. The sessions should be carefully planned.

The initial ones may be mainly to get acquainted, but be certain that this is acceptable to the participant. Many "leaders" never take time for such leisure encounters and will be disenchanted with the person who requests that they waste time this way. Future sessions should be with at least one preannounced item for discussion or it should be clear that it is just the best opportunity to get together. An excellent time for these sessions, is just after a meeting regarding a topic which deserves further attention, or just after a document comes to your attention regarding an issue about which you wish to learn more about or which you wish to share your ideas. Timeliness is extremely important. If the idea is too fresh and no one is interested, be careful about trying to develop a meaningful discussion about it. On the other hand, don't wait until the issue is so old and has been considered so frequently, that there is general boredom about it...unless, there is a new and innovative approach. After discussion of the immediate concerns about the issue, be prepared to recommend a "next step." These sessions should also be used to gather information from others. Leadership includes being able to ask the right questions, as well as having answers, and being capable of coordinating answers. Design the sessions to improve these skills. If carefully planned, each session will add a block or a piece of a block to the career pyramid. It is an extremely important tool.

The second set of "visibility" blocks will become available for the career pyramid, by volunteering or creating situations which result in being asked to participate in organizational activities which increase personal contacts. Agreement to serve in such capacities should be carefully considered, on the basis of whether the activity will improve visibility and increase opportunities to work with other leaders. A careful analysis of the responsibilities associated with the activity must be carefully completed before accepting the task. Choose those responsibilities which are of greatest benefit, based on personal goals, opportunities to demonstrate skills, opportunities to gather information and observe others who demonstrate leadership strengths. Sometimes an activity, chosen in order to gain exposure, will include many tasks which do not meet the career goals. That is to be expected. Every effort should be made, however, to insure that there are only a few of these incidents or that they do not require a major effort. Careful scrutiny of each activity, prior to acceptance, is the major way to prevent a mistake, and the luncheon networking system is an excellent way to gather information about the appropriateness of an activity. If it is an ongoing committee or activity, meet with the former leader, review minutes and meet with other members of the committee before agreeing to participate.

An example of an activity which is often not seen as being advantageous, but has great merit, is service on search committees. If this exercise is used advantageously, knowledge of the process by which additions are made to the organization can be of great benefit, by providing information on where the organization is going, new insight into the players in the process and probably most important, aspects of the application and candidate review process which will be of benefit when applying for new positions.

One will also learn how leaders make appointment decisions, including how nominations for positions take place, how they are influenced, how resumes are reviewed and perceived, and how the interview is planned. Personal preparation for future interviews become much simplier. In this regard, let me add, that there are those who believe that submitting resumes and participating in interviews, when one is not interested in the position, is a good idea, because it offers experience in the interview process. There is a negative factor which should also be considered. Participation in too many interviews, can result in being perceived as someone who has been unsuccessfully considered by many agencies. This could be detrimental to serious applications.

My third set of "visibility" blocks will take shape and begin maneuvering into a niche in the career pyramid, if community service, both political and non-political, is carefully planned. Some university administrative officers assign low priority to this element of the promotion and tenure process. Nonetheless, community service, if planned carefully, is an excellent tool for increasing visibility, while identifying and improving leadership related skills in an organization, university or otherwise. Failure to become involved in organizations external to one's major employment can result in job related stagnation. Serving in a "yeoman" capacity within the institution, and within the position which one holds, is important and necessary, but failure to be seen, heard and functioning in other organizations limits visibility. Getting involved in external organizations is, therefore, a must. If all attention is given to the present position and doing that job well, and for whatever reason, it does not lead to promotion, the opportunities outside the place of employment are usually more limited, because of lack of visibility. Probably more important, getting involved in external organizations gives one information which can be enlightening about trends in the field, future job opportunities, new careers and new directions, which one might take to prepare for a new career or advancement in the present career. Again, this should be planned. Don't waste time in organizations which are not related to the major career related direction unless there are very strong political or other forces which might make that decision a sensible one.

Some examples of organizations which consistently utilize outside consultants, volunteers, etc., are state and local health planning agencies, and non-profit health agencies, i.e. Red Cross, United Way. Attendance and participation in health research forums, and public hearings on health related legislation, can also result in major contacts with health leaders. Carefully review the available community agencies and choose a combination which best serves the goals of acquiring and demonstrating leadership skills.

If carefully developed, each of these three visibility block building ideas will lead to many new pieces of the career design being constucted. The key is careful, thoughtful placement of the blocks, preferably with a preconceived plan.

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A MODEL FOR NETWORKING AMONG LEADERS IN ALLIED HEALTH

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Any model developed to depict the reciprocal interfacing among leaders in Allied Health programs 10 years ago, probably would only include individuals who work primarily in disease prevention and sanitation programs. This limited view of the Allied Health Profession which was true 10 years ago, is no longer appropriate for our society as we move into the middle 1980's. The nature of health and disease has undergone tremendous change, so has the nature of Allied Health programs and their organizations. The leaders of various organizations, who are concerned with promoting Allied Health services and programs in the community, out of necessity, sometimes political, have become involved in issues such as reducing the danger to environment, constructing mechanisms to deal with stress, and control over-population through family planning.

Historically, leaders of Allied Health Programs have been involved in activities such as compiling vital statistics, the prevention of communicable diseases, and the safeguard for food and water supply for the public. Although, these issues remain key concerns of the leaders of Allied Health, nonetheless, the spectrum of the Allied Health profession can no longer exist within such a narrow picture.

Any attempt to discuss a model of networking among leaders in Allied Health would not be complete without including leaders of the Contemporary School of Allied Health. These leaders will come from areas such as home health services for the aged, prison health care, mental and emotional health services, (including suicide prevention and occupational safety and health), maternal and child-health care; and the prevention and management of addictive disease, such as drug and alcohol abuse.

A model that will incorporate the networking among Allied Health leaders, should evolve around five components. A high degree of interdependence should exist among the five components.

1. The first component should consist of leaders from those Allied Health programs, which personal care services include. These individuals should focus their attention on the prevention of disease, and the treatment and care of health problems affecting individuals within the community. Some of these leaders are physicians, nurses, physical therapists and health educators.

2. The second component should include leaders from those Allied Health Programs viewed as the watchdog for health safety. These leaders should focus their attention on reducing the chances of people becoming exposed to causative agents in the environment. Some of these leaders are epidemiologists, chemists, sanitarians and nutritionists.

3. The third component should consist of leaders from Allied Health programs which are responsible for training and educating individuals to become members of the health care team. The focus of these leaders attention is self-explanatory. They are responsible for educating the public, in matters of health enhancement, and training individuals to enter the Allied Health profession. These leaders come basically from colleges and universities' Allied Health programs.

4. The fourth component of this model, should consist of leaders from state and federal, Allied Health programs. They should be responsible for coordinating services, programs and activities for the purpose of providing a comprehensive and quality health care system for the nation. These leaders are associated with the Department of Health and Human Services, Environmental Protection Agency, and the Food and Drug Administration.

5. The fifth and final component of this model, should incorporate those leaders who come from official and voluntary agencies which provide the human, financial and material resources to sustain an Allied Health program. The focus of these leaders' attention is based on a supported service function. That is, to provide whatever resources are needed, for the purpose of supporting a quality Allied Health program.

The network of leaders which comprises this fivefold model has the responsibility of providing a quality Allied Health program to all individuals who need it.

This network of leaders has the responsibility of addressing many important issues concerning the Allied Health profession. Among those issues are Declining Minority Student Enrollment, the lack of Minority Faculty in Allied Health Education and the lack of knowledge regarding the Allied Health profession among educational administrators and the general public.

DECLINING MINORITY STUDENT ENROLLMENT

One way for the network of leaders in Allied Health to curtail this problem, is through intense marketing of its product. The key marketing tool at their disposal is telecommunication, television and other media which illustrate or portray the roles of minorities in the Allied Health professions, in the positive manner, definitely could play a major part in recruiting more minority students in Allied Health fields.

Another way of recruiting minority students in Allied Health fields is the development of a National Recruiting Bank by the leaders of Allied Health professions. A sharing arrangement of this nature, for the purpose of distributing literature concerning the opportunities in the Allied Health field for individuals could serve as a vital tool in recruiting minority students from high schools for the Health Professions and Community Colleges.

LACK OF MINORITY FACULTY IN ALLIED HEALTH EDUCATION

It is quite evident that, in the past, and even today, in some sections of America, little attention has been given to the delivery of health care to minorities. It is no surprise that this issue has been a low-priority in these United States. This lackadaisical attitude (if we choose to call it that) contributed immensly to the lack of participation by minorities in Allied Health professions. Again, a major ingredient in correcting this problem is telecommunication. In addition to telecommunication, is the development of more Allied Health programs at predominantly Black institutions. These programs will not only increase the number of minority faculty members but the quality of them.

LACK OF KNOWLEDGE REGARDING THE ALLIED HEALTH PROFESSIONS

The network of leaders in the Allied Health professions should provide conferences, seminars and workshops on the Allied Health professions. These conferences, seminars and workshops should include hundreds of citizens, ranging in the backgrounds from housewives to students, from professors to truck drivers. These conferences, seminars and workshops will provide those who are involved with this endeavor, with opportunities to focus their communicative and social skills, their imagination and creativity as well as their decision-making abilities on developing strategies to help educate individuals on the role and function of Allied Health professions.

The impact that Allied Health will have on the public depends on how well serious minded leaders of the Allied Health professions collectively communicate each issue concerning Allied Health to those individuals who are entrusted with carrying out the functions of the various governmental structures in America.

Any model developed for networking among leaders in Allied Health must be designed within the framework of the passage from Public Health Reports, June 12, 1914.

Public Health Administration in a community is as extensive, and the health department is as efficient, as the people want it to be. Health Administration can neither exceed to any great extent or lag far behind the wishes of the people.

A MODEL OF THE NATIONAL JOURNAL OF ALLIED HEALTH

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GOALS OF PROPOSAL

The goals of this proposal are to (1) plan a written means of communication to improve research, education, and administration among allied health professionals; (2) request and secure cooperation from the leadership of the National Society of Allied Health to develop, produce and distribute "Journal" issues and (3) bring about an overall improvement in allied health professional performances by providing a journal which links constituents, within a network, for the exchange of research findings and outcomes of tryouts of educational models.

The proposed "National Journal of Allied Health," (NJAH) will be a regularly published periodical, initiated through this proposal, and continued through leadership support. It will devote special efforts toward bringing to the attention of the health professionals and others, projects and scientific outcomes of programs and projects, which are of special interest to, or focused on minorities. It will, of course, present health issues, projects and findings which are applicable to, or of interest to, all of the allied health, medical or dental communities.

PURPOSE OF JOURNAL

The purpose of NJAH is to provide an official journal of the National Society of Allied Health faculty, researchers and practitioners trying out emerging techniques, to publish and expose their findings to others. At present, there does not exist in the United States a medium which provides professional publication opportunities for projects having special interest to allied health professionals.

Networks exist which have journal opportunities for minority-focused projects for dentists and physicians, but no allied health fields have organized network media or publications. Specific journals referenced are the journals of the National Dental Association and the National Medical Association.

Minorities comprise in excess of 60,000 professionals in 21 allied health fields proposed to be included in the network served by NJAH. They are those listed below. A few other categories will be included when the curriculum or practice is similar to those listed, such as respiratory therapy technician or music therapy.

Dental Assistant
Dental Hygienist
Dental Laboratory Technician
Dietitian
Dietary Technician
Inhalation Therapy Technician
Medical Laboratory Technician
Medical Record Librarian
  (Medical Records Admin.)
Medical Records Technician
Medical Technologist
Occupational Therapist
Occupational Therapy Assistant
Ophthalmic Assistant
Optometric Technician
Optometric Technologist
Physician Assistant
Physical Therapist
Sanitarian
Sanitarian Technician
Radiologist Technologist
X-ray Technician

OBJECTIVE OF JOURNAL

The objectives of the National Journal of Allied Health are to:

1. Provide for the publishing of scholarly papers, and reports of recent development and findings in research, education, administration and practices in Allied Health fields. Current trends, history and models will be reported in the journal.

2. Encourage the publication of articles, reports, research abstracts, letters to the editor, and book reviews, in the NJAH, having particular application to minorities, and which are interdisciplinary in focus. Articles published in NJAH will be accepted with the understanding that they are being published exclusively in NJAH and not submitted elsewhere for publication.

3. Establish an editorial board and staff responsible for directly or indirectly:

    a. maintaining constant communication with constituent disciplines, to remain current and aware of changes affecting the disciplines;

    b. invite experts to write manuscripts and provide those experts with authoritative guidance on carefully chosen subject areas;

    c. provide careful editing of articles so that they are concise and to the point, yet in conversational style;

    d. highlight diagnostic therapeutic and clear steps to programs and practices which can be immediately applied by readers;

    e. arrange for authors and consultants to answer questions written to NJAH;

    f. provide career employment opportunities;

g. provide limited advertisement space for appropriately related products.

4. Establish requirements for articles and manuscripts. Define copy preparation requirements, length and style guidelines, table, diagram, and illustration regulations and review criteria.

5. Edit, print, publish and distribute copies of NJAH.

NJAH DESIGN AND DEVELOPMENT

Developing NJAH will be designed as follows:

1. Presentation of this plan to board including financing and development details: Finance will be sought in year 1 through Federal contract support. Year 2 and subsequent years are planned as self-sustaining years. Plans are initiated on the following beginning framework.

   Year 1

   Funding support through contract with DHHS has been requested for development and printing of the first issue by Dr. Everlena Holmes, Past President of NSAH. Funding support will provide a limited first edition in 1984, if secured.

   Year 2

   An editorial board designation is requested from the Executive Staff of the National Society of Allied Health. Pending approval, action is being initiated.

   a. Designation of Editorial Board.

   b. Defining of guidelines at NSAH annual session and call for papers.

   c. Call for papers.
      Receipt, editing, printing

   d. Publishing and distribution.

Guidelines which will be issued at the NSAH annual meeting in the Call for Papers are:

The National Journal of Allied Health (NJAH) considers scholarly reports and papers for publication. Articles and studies regarding recent developments and findings in research, education, administration and applied practices or current trends or the history of allied health disciplines are welcome contributions.

NJAH particularly encourages the publication of reports, abstracts, books, reviews and letters to the editor which are relevant to minorities and women, while at the same time, are of interest to all sectors of the allied health community. Articles which are interdisciplinary in focus and well documented are encouraged.

Any article considered for publication is accepted with the understanding, that it is being published with appropriate permission for citations having been secured by the author, and responsibilities of accuracy and validity of content resting with the authors.

All contributions will be reviewed by the editorial board for acceptability. Manuscripts accepted for publication are subject to editing and consideration by the editorial staff or consultants. Edited copy is sent to the author. Generally, proofs are mailed to the author for correcting errors and should be returned within 24 hours of receipt. Errors should not be corrected on galley proofs. Word deletions should be corrected using words of similar lengths, otherwise full paragraph reset is required by printer.

Manuscripts. Original and two photocopies of manuscripts should be submitted. Authors should retain a duplicate copy of all submissions. Copies submitted will not be returned.

Abstracts. Abstracts of manuscripts should be submitted with manuscripts. Abstracts should be less than 150 words. It should summarize the objectives, facts and conclusions of the manuscript.

Copy Preparation. Manuscript and references should be typed in double spacing, on 8½ x 11 inch white paper, with one inch margins on all edges. Papers must be numbered. A separate cover should indicate the name, address, title, institution, and telephone number of the author, exactly as it will be printed on final copy. Authors must be be identified only on separate cover so that articles may be received confidentially.

Length of Manuscript. Major articles are generally limited to 3,000 words, or 15 double-spaced pages, including references, tables and attachments. Footnotes should be minimal and no more than two or three lines in length.

Style. It is recommended that authors follow the guidelines for style of the Manual for Authors and Editors of the American Medical Association.

Papers presented at meetings should include a footnote giving date, name, and place of meeting. Use the following symbols to designate footnotes: *,+,‡.

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POWER: HOW TO GET IT, USE IT AND KEEP IT

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The political and economic bodies that affect society policy are led and staffed at the highest levels by White males. In addition, economic institutions and corporate policy are exclusive White male preservers. In our country, where wealth and economic power are privately held and minimally influenced by government, the all-male exclusivity has made inevitable consequences for minorities. Margaret Hennig wrote:

> "In most organizations, the informal system of relationships finds both its origins and present function in the male culture and in the male experience. Its form, its rules of behavior, its style of communication and its mode of relationships grow directly out of the male developmental experience."

In short, White men have established the vast majority of organizations in this country and the male culture is dominant. Consequently, one major barrier to obtaining strategic corporate information is the exclusion of minorities from the tightly organized social systems of top management, such as the clubs where business is discussed and deals are made.

"Huddling" is a term associated with an informal organizational structure. Trust, intimacy, and smooth working relationships are prerequisites for effective huddling activities. Minorities have not been a part of the old-boy network--the "kitchen cabinet" familiarities, weekend games, after-hours socializing and chauvinistic joking that creates the friendly, comfortable relationships through which networks of power are forged.

One needs to know how communication flows in the whole organization and how to systematically tap the flow for needed information. One must explore the informal methods of communication like "the old-boy network" which has considerable power; if you're "in," you get the needed information, if you're "out," you are in the dark.

Hennig, Jardim, Sheehy, Ginzberg, Bird, Tyler, Mills-Novoa, and others have described the informal system of power that is at the heart of middle management. Most minorities are unaware of its existence. The insiders operate knowledgeably and carefully within an informal system of relationships, which provides information sharing, ties of loyalty and of dependence, of favors granted and owed, of mutual benefits and of protection. Erikson suggested that no doubt there exists among men an honest sense of wishing to save, at whatever cost, a sexual polarity, a vital tension, and an essential difference, which they fear may be lost in too much sameness, equality, and equivalence, or at any rate, in too much self-conscious talk.

Faced with no formal authority, one must rely on "influence," an outcome of previous experiences based on persuasion, friendship, favors granted and owed, and promises that must be kept.

It is not enough for minority organizational stars to be bright, able and energetic, they must also learn the informal rules of business behavior that some take for granted.

If minorities can enter this informal White power system, and become members of key informal groups, such entry is beneficial to career advancement. Emphasizing the development of opportunities through the informal system demands an active strategy called networking.

Networking is the word used interchangeably to describe a concept, a technique and a process. It is an advanced way of thinking about how people bypass formal organizations and procedures, to cut through resistance and get things done easily, just because they know each other well enough to get in touch informally. Networking gives an unfair advantage and is very effective.

Networking as a process, involves a chain of interpersonal connections. By using others as contacts to gain access to information, one can extend communication lines and build a communications network.

Potential linking processes can take many forms, including: (1) interpersonal ties, (2) overlapping memberships, (3) change-agent roles, (4) the established linking system, and (5) special information receiving and sending roles within the organization.

As a technique, networking is the art of deliberately developing and using contacts. With the conscious use of the intrapersonal lines of communication, personal contacts will develop to promote career strategies.

Contacts that develop into trading relationships can evolve from personal acquaintances, informal business transactions, informal social settings, and through informal usage. The network of relations develops as a functional dimension of the organization, providing the opportunities for resource exchange and information exchange.

Leonard Sayles believed that, in the process of making each unit of the organizational structure effectively contribute to the goal, the occupants must engage in personal transactions, which he calls "exchanges" of information.

Networks supply a variety of information to their members, such as the latest gossip about interpersonal conflicts or affairs, inside information on job openings or terminations, information on relevant articles in professional journals, notices of conferences or workshops, and previews of organizational problems. Access to this information is crucial.

There are ways to penetrate the system. The first step is to become an astute observer of powerful people, those who are most likely to have, hold and pass along useful information. Second, tap the gossip system. A third way is to read notices on all bulletin boards regularly. Another is to be listed on the routing slips of important trade and professional journals. You can gather information about who the people are who sponsor, give advice, get the best projects; and then patterns will appear.

The U.S. Bureau of Labor Statistics shows that 47 percent of all jobs come through personal contacts. Similarly, Josefowitz, in her study, states that only 10 percent to 40 percent of all jobs are found through advertisement, all others are obtained through personal contacts.

The effects of networking have been studied to a limited extent. In a recent study, Barnier discussed the informal system and networking as they are related to the development of leadership, power, and skills that an individual needs to advance in his career. She noted that White men have easier access to the informal system and that minorities must develop their own systems in order to accelerate their advancement.

Mills-Novoa, in her study, recommends organizational interventions to increase contact with power holders in the organization, and hence, increase access to resources and opportunities within the institution. Information exchange, communication channel-opening, input into the decision-making process prior to the time the decision is made, all characterize the informal associations within the organization.

In order to survive with the informal organization, Jennings suggests that there be strategies for moving ahead: map the political terrain, write your own informal organizational chart, and know the internal politics of the organization.

Find out who is really influential, who has the real power, who is moving up, who controls the resources, who has the access to important information, and who makes decisions. Patterns will begin to unfold. One may not fully understand what goes on behind closed doors, but you will at least know who is there.

Informal associations extend both inside and outside the organization, providing the opportunity for the exchange of information, for the testing of ideas, and for access to secret know-how. Drinks at the local bar after work, or socializing over the weekend at athletic activities, are part of the pattern.

To become a more effective networker, one must have power. Minorities have probably always been more suspicious of power because of their victimization. And, recent political processes seem to confirm that distrust. We tend to equate power with exploitation and corruption. The negative aspects of power have blinded us to its positive points, to its uses, and to the fact that without it people cannot accomplish very much anywhere.

This fact is especially true in management. I am reminded of the uses of power during the sixties. The concept of Black power was not appreciated by some Blacks. They believed the underlying concept could be best expressed by a term like "brown strength," Black power was too negative.

One of the many consequences of this attitude is that power as a topic for rational study and dialogue has not received much attention, even in management circles. If you doubt this, all you need to do is flip through textbooks, journals or advanced management course descriptions. The word "power" rarely appears.

This misunderstanding is becoming increasingly burdensome because in today's large and complex organizations, the effective performance of most managerial jobs not only requires one to be skilled in networking, but also the acquisition and use of power.

The successful manager acquires power by being able to answer the following questions:

1. Why are the dynamics of power necessarily an important part of the managerial processes?

2. How do effective managers acquire power?

3. How and for what purpose do effective managers use power?

Most experts identify the following kinds of power:

1. Legitmate Power: That power given to an individual by right of the role or position he holds in the organization. The president of an organization certainly has more power than the janitor. The president can influence or control people and situations by the right of his role, regardless of his personality.

2. Reward Power: That power an individual holds because he can give something to someone else. If someone supports your position you will do a special favor for that person.

3. Coercive Power: That power an individual holds because he can withhold or take away something of desire from

someone else. "If you don't get this job done by Tuesday, you're fired!"

4. Expert Power: That power an individual holds because of the knowledge or expertise he or she has. If we were going to plan an international convention, we would include an expert on international conferences in our planning group. In this case this person would have expert power in our decision making.

5. Referent Power: That power an individual holds because of his charm or personal magnetism. Just as Pied Piper led a pack of rats, some people can lead others by their charisma. They may or may not hold any other power, but people do listen to them and follow them. It might be for good (John Kennedy) or for bad (Adolph Hitler).

The successful manager must acquire as many combinations as possible. You must not simply rely on your legitimate and expert power.

One of the distinguishing characteristics of a typical manager is how dependent he is on the activities of a variety of other people to perform his job effectively. Successful managers cope with their dependence on others by being sensitive to it, by eliminating or avoiding unnecessary dependence, and by establishing power over those others. Good managers then, use the power to help them plan, organize, staff, budget, evaluate, and so on. In other words,it is primarily because of the dependence inherent in managerial jobs that the dynamics of power necessarily form an important part of a manager's processes.

To help cope with the dependency relationships inherent in their jobs, effective managers create, increase, or maintain four different types of power over others. Having power bases in these areas puts the manager in a position both to influence those people on whom he or she is dependent when necessary and to avoid being hurt by any of them.

Successful managers often go out of their way to do favors for people who they expect will feel an obligation to return those favors. Recognizing that most people believe that friendship carries with it certain obligations "a friend in need....," successful managers often try to develop true friendships with those on whom they are dependent. They will also make formal and informal deals in which they are dependent. They will also make formal and informal deals in which they give something up, in exchange for certain future obligations.

A second way successful managers gain power is by building reputations as "experts" in certain matters. Believing in the manager's expertise, others will often defer to the manager on those matters. Managers usually establish this type of power through visible achievement. The larger the achievement and the more visible it is, the more power the manager tends to develop.

A third method by which managers gain power, is by fostering others unconscious identification with them or with ideas they "stand for." Sigmund Freud was the first to describe this phenomenon which is most clearly seen in the way people look up to "charismatic" leaders. Generally, the more a person finds a manager both consciously and (more important) unconsciously and ideal person, the more he or she will defer to that manager.

Managers develop power based on others' idealized views of them in a number of ways. They try to look and behave in ways that others respect. They go out of their way to be visible to their employees and to give speeches about their organizational goals, values, and ideals. They even consider, while making hiring and promotion decisions, whether they will be able to develop this type of power over the candidates.

The final way that an effective manager often gains power is by feeding others beliefs that they are dependent on the manager either for help or for not being hurt. The more they perceive they are dependent, the more most people will be inclined to cooperate with such a manager.

There are two methods that successful managers often use to create perceived dependence:

Finding and acquiring resources. In the first, the manager identifies and secures (if necessary) resources that another person requires to perform his job that he does not possess, and that are not readily available elsewhere. These resources include such things as authority to make certain decisions, control of money, equipment, and office space, access to important people, information and control of information channels and subordinates. Then the manager takes action so that the other person correctly perceives that the manager has such resources and is willing and ready to use them to help (or hinder) the other person.

Affecting perceptions of resources. A second way effective managers gain these types of power is by influencing other persons perceptions of the manager's resources. In settings where many people are involved and where the manager does not interact continuously with those he or she is dependent on, those people will seldom possess "hard facts" regarding what relevant resources the manager commands directly or indirectly (through others), what resources he will command in the future, or how prepared he is to use those resources to help or hinder them. They will be fored to make their own judgements.

Insofar as a manager can influence people's judgements, he can generate much more power than one would generally ascribe to him in light of the reality of his resources.

Before discussing how managers use their power to influence others, it is useful to see how formal authority relates to power. By formal authority, I mean those elements that automatically come with a managerial job - perhaps a title, an office, a budget, the right to make certain decisions, a set of subordinates, a reporting relationship, and so on.

Effective managers use the elements of formal authority as resources to help them develop, any or all of the four types of power previously discussed, just as they use other resources (such as their education). Two managers, with the same formal authority, can have very different amounts of power entirely because of the way they have used the authority. For example:

- By sitting down with employees who are new, or with people who are starting new projects, and clearly specifying who has the formal authority to do what, one manager creates a strong sense of obligation in others to defer to this authority later.
- By selecting, withholding or giving the high-quality service his department can provide other departments, one manager makes other managers clearly perceive that they are dependent on him.

On its own, then, formal authority does not guarantee a certain amount of power, it is only a resource that managers can use to generate power in their relationships.

Successful managers use the power they develop in their relationships, along with persuasion, to influence people on whom they are dependent to behave in way that make it possible for the manager to get his job done effectively. They use their power to influence others directly, face to face, and in more direct ways.

Managers who are successful at acquiring considerable power and using it to manage their dependence on others tend to share a number of common characteristics:

1. They are sensitive to what others consider to be legitimate behavior in acquiring and using power. They recognize that the four types of power carry with them certain "obligations" regarding their acquisition and use. A person who gains a considerable amount of power based on his perceived expertise, is generally expected to be an expert in certain areas. If it ever becomes publically known that the person is clearly not an expert in those areas, such a person will probably be labeled a "fraud" and will not only lose his power but

will suffer other reprimands too. A person with whom a number of people identify is expected to act like an ideal leader. If he clearly lets people down, he will not only lose that power, he will also suffer the righteous anger of his ex-followers. Many managers who have created or used power, based on perceived dependence, in ways that their employees have felt unfair, such as, in requesting overtime work, have ended up with unions.

2. They have good instructive understanding of the various types of power and method of influence. They are sensitive to what types of power are easiest to develop with different types of people. They recognize, for example, that professionals tend to be more influenced by perceived expertise, than by other forms of power. They also have a grasp of all the various methods of influence and what each can accomplish, at what costs, and with what risks. They are good at recognizing the specific conditions in any situation and then at selecting an influence method that is compatible with those conditions.

MODEL HEALTH PROFESSIONS COUNSELING PROGRAM FOR SECONDARY STUDENTS IN AN URBAN SCHOOL SYSTEM

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PURPOSE & ORGANIZATION OF PROJECT

Lack of adequate guidance and counseling programs concerning the allied health field for secondary and minority students resulted in the development of a thirteen-month experimental Model Secondary Education Health Professions Counseling Program in the Cleveland Public Schools. The program was funded by the Bureau of Health Manpower, Division of Associated Health Professions, Department of Health, Education, and Welfare and was established under the local school system's Division of Guidance, to demonstrate how a program of this kind, might operate in an urban school system. This model pilot program was tested, implemented and evaluated for one year (July, 1975-76). Funding was then extended for 36 months ending in June, 1979.

The "Allied Health Careers Program" (as the program was known) in the Cleveland Public School System, was established in five senior high schools with high proportions of minority groups students. These schools were chosen on the basis of the minority student population, and the willingness of the principals in those schools to accept the program.

Four non-participating senior high schools were also selected as control schools, because of similar geographic and economic characteristics as those of the project schools.

In three of the project schools, over 99 percent of the students were Black. The fourth school, which was located in a predominately White area, had a 9 percent minority group level. The fifth school had a 26 percent minority group level, of which 19 percent consisted of Spanish - surnamed students.

The Model Health Professions Counseling Program was unique in that only one other secondary school system had a program such as this in the United States. The other program was located in New Orleans, Louisiana.

CONTENT OF PROGRAM

STEP I. Organization of an Advisory Committee - In the development stages of the program, health service agencies and institutions, colleges and universities were contacted for the purpose of assessing the allied health services and training institutions in the community. It was through these initial contacts with various occupational personnel that names of persons representing a cross-section of health related professions were obtained as possible advisory members. From these contacts a nine member Advisory Committee was organized. The purpose of the Advisory Committee was to offer expert counsel and professional opinion as to the direction and methods employed in accomplishing program objectives and to make suggestions for future and follow-up activities. The Advisory Committee met three times a year.

STEP II. Methodology of Program - Minority students have had limited exposure to role model identification and experience with the diversity of opportunities available to them in the health field. In order to meet these needs, the program was based upon six program phases.

1. Orientation Sessions for 10th Grade Students.
2. Health Careers Course.
3. Staff Development Workshops.
4. Individual/Group Counseling and Resources Service.
5. Development of Program Guide and Kit.
6. Contact with Health Professions Personnel, Agencies and Training Institutions.

STEP III. Selection of Students - Most students face a difficult task in completing career decisions and related preparation. Therefore, the Allied Health Careers Program, was open to all interested secondary students in the five participating schools. Program emphasis, however, was geared to tenth grade students.

STEP IV. Control Group Selection - Four senior high schools were chosen as control institutions. This was done in order to compare the program impact of student participants with that of the comparison group students. These schools were selected because they had similar geographic and economic characteristics to those of the five project schools.

Students were selected from a random sample of tenth grade classes by the counseling staff. Level of interest in health careers was not a factor in the selection of control group students.

PROGRAM ACTIVITIES (First Semester: September-January)

PHASE I. Tenth Grade Orientation: The overall objective of the orientation sessions was to broaden student's information base and to stimulate awareness of and interest in the allied health professions.

The intent of the Tenth Grade Orientation was to reach all tenth grade students, through small group sessions, in the five project schools during the first semester from September-January.

It was Cleveland Public Schools' policy, that all tenth grade students take English. Therefore, conducting health career sessions through the English classes and/or Study Hall were the most effective ways of reaching most tenth grade students.

Guidance Counselors in the five project schools, scheduled the orientation sessions, which were planned and conducted by the Project Coordinator. The course of study included an introduction into the allied health careers and preparation needed to enter these careers.

Orientation sessions included lectures, role model presentation, films, slides and the distribution of career material information.

PHASE II. Health Careers Course: (Second Semester: January-April).

The purpose of the Allied Health Careers Course, was to offer to students descriptive and informative insights into at least thirteen allied health professions and identify, by consultation, with seven or more allied health professionals.

Telephone calls were made to area colleges and universities, health services agencies, hospital and local health service associations, to explain the program, the pending classes in the five project schools, and the need for allied health career speakers for these classes. A schedule for the health careers course was then developed, including the day and dates that classes were to be held and the speakers for each of the five schools.

The schedule, accompanied by a letter outlining the course was sent the school administrators, head counselors, and the health career counselor in each of the project schools. Details of time and place of classes were later discussed with the counseling staff prior to the implementation of the course.

Course of Study - The course provided a series of ten weekly sessions in each of the five project schools. The Project Coordinator presented an overview of allied health careers and description of the course. Each of the following seven classes focused on the specific health career and provided a resource person (role model from the designated fields).

The allied health areas, covered by the seven to eight resource persons, were identified based upon the interest shown by the students in a given school. Thus, the areas covered varied among the schools. The ninth and tenth classes included a field trip to a local health care agency, and a joint program included student participants in the five project schools. The tenth class varied each year and was usually in the form of a field trip to an out-of-town college or university, a Career Day, or an Articulation Workshop, presented in conjunction with an area college or university as the concluding session.

Articulation With College Program - A variety of activities were provided for participating students in conjuction with area colleges and universities. Activities included special programs, such as Staff Development Workshops, Tours, Career Days, seminars, and presentations.

PHASE III. Staff Development Workshops

Staff Development Workshops were developed for the purpose of acquainting guidance counselors in the five project schools and junior high feeder schools with the Allied Health Careers Program. The workshops also served to acquaint guidance counselors with post high school training, and other academic programs, financial assistance available, and the wide scope of allied health career opportunities. Counselors were given information about recruiting role model speakers, where to obtain audio-visual material and other program tools useful in working with students.

PHASE IV. Individual/Group Counseling and Resources Service

Through the Allied Health Careers Office, every effort was made to respond to students, teachers, counselors, parents, community agencies, hospital personnel, school administrators and others, who requested information about the health professions field.

PHASE V. Development of Program Guide and Kit

An Allied Health Careers Kit was developed concurrently with Model Allied Health Professions Counseling Program Guide for Secondary School, at the end of the pilot year of operation. Revision and additional resources were added each year.

The Kit and Guide served as a resource tool in conducting sessions with students, counselors, teachers and parents in the five project schools. It was designed to provide the user with concise, fingertip information about the health professions field and the various phases and activities of the specialized program.

PHASE VI. Contacts with Health Professions Personnel, Agencies and Training Institutions

Extensive contact with persons representing a wide range of post secondary health professions, service agencies, and training institutions were developed and maintained by the Health Careers Coordinator. The contact conducted by telephone, correspondence and personal visits, focused upon acquainting the health professions personnel with the program, eliciting their support in providing resource persons, field trip sites, and in promoting the availability of placement opportunities for participating students.

EVALUATION AND OUTCOMES OF MODEL PROGRAM

Outcomes: Health Careers Plans of Graduates - Participants vs. Comparison Group Students

Follow-up data were collected to compare the level of post-graduation health careers employment/further training of program participants with that of comparison group students. Each group was given a health careers survey.

The analysis of post-graduation plans of the project participants and the comparison-group revealed that the participant group had a markedly higher proportion of students expressing the intention to pursue further education. The percent of participants indicating plans for further studies for training was 84.5 percent - 82.8 percent on a full-time basis and 1.7 percent on a part-time basis. Among comparison-group students, 59.4 percent intended to pursue further studies or training - 55.1 percent on a full-time basis and 4.3 percent on a part-time basis.

These findings suggest that students who participated in the specialized health professions counseling program promoted greater awareness of and motivation to pursue further training or study following graduation. Involvement in program activities stimulated students to clarify their career plans, to recognize the need for specialized preparation, and to undertake the additional training or study needed to pursue their intended goals.

Impact of the Model Project on the Community since 1979 when Project Ended

I. The development of a Magnet Health Careers Center, a comprehensive vocational high school - Cleveland Public Schools.

The Health Careers Center offers six, two-year programs, in the following areas: Nurse Assistant, Optical Assistant, Operating Room Assistant, Dental Assistant, Dental Laboratory Assistant and Medical Laboratory Assistant.

II. Key Organizations and Leaders networking together to prepare more minority health care practitioners for the future. For example: The hospital at which I am now employed, Kaiser Permanente Health Plan of Ohio, awards each year, $500.00 scholarships, to six graduates of the Health Career Center. The scholarships, renewable for four years, are a part of a $56,000 grant made to the Health Careers Center, from the Community Services Program of Kaiser.

III. My position is Director of Volunteer Services at Kaiser. Although I am not directly involved in Allied Health, per se, I feel committed to help minority students get clinical experience and exposure to various health careers. This is done by providing observation and clinical experiences for high schools and other health related training institutions through the Volunteer Services Department.

IV. I willingly accept the opportunity to talk to students and school Guidance Counselors, about the Allied Health field, and keep abreast of current trends in health care job opportunities and needs in the greater Cleveland Area.

ACTION STRATEGIES ON NETWORKING FOR EDUCATIONAL INSTITUTIONS AND PROFESSIONAL ORGANIZATIONS

By

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It is difficult to come before you at this time and talk about "action strategies on networking," after we have heard so many eloquent speakers address the issues in previous presentations. I view this opportunity to speak as a means of re-emphasizing your thinking for the breakout sessions to follow.

Before I get into the subject of networking, I would like to ask a question that I hope you will give some thought. As members and officers of the National Society, "What business are you in?" Certainly, the goals and objectives of the organization indicate that "The allied health business" would be the most likely response. Assuming that this the consensus of the group, I would like to share a short story with you.

I'm sure most of you have heard of the Pennsylvania Railroad. This company, at one time, was a thriving business serving as a link between cities thoughout the country. Its assets totalled in the millions, and it was one of the major support services during the industrial and agricultural booms of America in the early to mid 1900's. But eventually the company found itself in a tremendous financial predicament and on the verge of bankruptcy. As with most companies of its size, it appealed to the government and to the non-governmental agencies for help in bailing out of its financial difficulties. At one of its many hearings, the question was asked of its leadership, "What business are you in?" The response was "We're in the railroad business." This comment indicated the reason for the ultimate demise and the seed of the destruction of the company. For some time later, the Pennsylvania Railroad folded and closed its operations permanently. The most appropriate answer to the question should have been: "We're in the transportation business." For had they answered in those terms, they may have become the Federal Express of today. The nature of their business is that of moving goods from one place to another or from one part of the the country to another.

What's the lesson of this story? If you are telling me that the National Society of Allied Health is in the business of allied health, then I think you're in trouble, because you've got to relate your existence to the total health care delivery system or the "big picture." This is why there has to be some synergism with other organizations. We must fully understand the impact of what's happening in the health care industry, because its going to bear on the viability of the NSAH.

A case in point would be the message given to some of you and your colleagues at the annual ASAHP meeting in November of last year, wherein Dr. Robert Graham states that, "The allied health professions are faced with a set of peculiar and troubling issues," and warned that allied health educators will have to make their case better at the federal level, as such programs must compete for limited federal education support. He states further, that even if more resources become available, they may be allocated to other types of educational support.

The implications of Medicare payments under the new prospective payment plan will have a tremendous impact on Allied Health Professionals. As hospitals receive less money and flat fees are paid for certain diagnoses rather than for actual treatment costs, allied health professionals will have to demonstrate their value to prevent being "squeezed out" by physicians and other providers trying to "protect their turf."

If, because of Medicare, hospitals opt to hire more technicians and fewer technologists, more assistants and fewer therapists, and more practitioners prepared at the associate rather than the baccalaureate degree levels, the implications for Allied Health Educators at Black institutions may require a re-examination of program offerings in the future years. Medicare, DRG's, PPO's and Medicaid are subjects that traditionally have not been the special concern of Allied Health Professionals.

Today, we are living in an era of government by regulation, not legislation. In all honesty, it has taken the health and medical profession quite awhile to wake up to this fact.

I'm especially concerned that unless Allied Health Professionals and Educators not only wake up but begin to show more concern for the issues affecting the delivery of health care, they may awaken to find that it is too late to influence decisions affecting their future as contributors in the health care system.

Webster defines networking as "the exchange of information or services among individuals, groups or institutions." Although the word "communication" is not mentioned, it must be addressed if we are to fully understand networking. Strong, two-way communications is a pivotal problem in all organizations and in our dealings with others in our personal lives. In nearly every situation, once the lines of communication are untangled, the knots in every thing else seem to unravel as well. The most common definition of communications is "a process by which information is exchanged between individuals through a common system of symbols, signs or behaviors." At its most basic, this is the essence of effective communication. This exchange of information is the backbone of any organization, and the successful exchange of information is what separates strong, effective organizations from those that will remain only loosely bound groups of people, held together by things - membership cards, etc. - rather than by common goals and ideals.

The successful exchange of information depends upon a common system of symbols, signs or behaviors. Without these, the exchange of information becomes a useless exercise.

Searching for commonality among people, diverse as all the individuals who make up the National Society, may be a large undertaking. After all, we are from different states, different work environments, and even different occupations within the health profession. To truly communicate with one another at all levels must be our goal.

If the National Society of Allied Health is going to effectively exchange information with other groups, there are basic steps that must be followed. First, the Society must clearly define the purpose of networking. Let me share with you a few purposes for your examination. This is by no means an all inclusive list:

1. Peer Fellowship

    A. This provides us with a reason why we as minorities should get together.

    B. It also helps us to sensitize our collective thinking and to share our concerns and experiences.

2. Advocate of Public Policy

    A. This purpose could enhance the credibility and viability of an organization, if the organization can develop the political muscle necessary to sustain public policy positions, on a local and/or national level.

    B. This purpose might also contribute to the organization's ability to achieve its mission and goals.

3. Commitment to Our Youth

    A. This purpose depends on educational institutions whereby youth can associate with role models. To the extent that this is done, we all gain. The better we prepare our youth, the better we will be prepared as well.

An organization must assess its strengths as to its ability to carry out one or more networking purposes. It may very well be that the organization can have but one purpose. It's better to do one well, than to do five very poorly. At some point, the National Society will have to determine its networking purposes and then place each purpose in a high priority, medium priority or low priority position. It will have to take a good look at its resources, and assess the commitment of its members to accomplish its stated purposes.

Networking is therefore a part of the activities that help the organization to carry out its corporate mission. The corporate mission must be distinguished from the purposes of networking. However, I must emphasize that each relates directly to the other.

Once the purposes have been determined, and the priorities have been set, the next step would be to set outcomes. We have to establish some yardstick by which the organization measures its success. For example, if a purpose of networking is peer fellowship, a goal might be to increase membership and to have 500 attendees at the next annual meeting. A workshop could be planned at the next annual meeting whereby strategies could require that certain members be notified in advance to come prepared with the names, addresses, titles, etc. of ten allied health professionals. The purpose of the workshop would to be to compile, collate, eliminate duplication, etc., so that at the end of the workshop session you have a new list of potential members.

Crucial to the success of the organization, in my opinion, is the need to identify a series of short range objectives that are achievable within the year and can be reported at the next annual meeting. These accomplishements should be utilized in a way that they will be used as tools in addressing the public relations, marketing and membersnip needs of the organization.

Organizational changes may be indicated, based on the networking purposes you identify. For example, there may be a need to establish a membership committee and a public relations committee in order to advance the objectives of the Society.

I would like to suggest that the Society consider the following ideas to improve as an organization.

1. Now that we have a logo, use it on everything from letterhead to brochures to neckties (If you're into that).

2. Have a short slogan and use it repeatedly.

3. Publish a membership directory with lots of supplementary information - officers (past and present), committees, and their members, constitution and bylaws, award recipients, staff, etc.

4. Continue to use the organization's brochure. You need to tell everyone - members, prospective members, who you are and what you do.

5. Organize a Legislative Keyman Network. As a national organization, you'll need lots of trained eyes and ears to keep track of proposed legislation and regulations.

6. Establish a Public Information Network. A trained force of ready and able spokespersons for your profession can do wonders for your organization.

7. Consider offering insurance programs for members.

8. Involve your members by offering them a mail ballot or try an absentee ballot system on voting items.

9. Take the time to develop a long range plan.

10. Establish a newsletter to keep everyone informed and "on the inside."

11. Develop a membership list.

12. If you can afford it, you'll get great respect for sponsoring a legislative or research associate program.

13. Give lots of awards - to committee chairpersons, for outstanding performances for the Society, to the Member of the Year.

14. Create a Monthly Master Calender of Meetings.

15. Take a risk on a big project every five years or so.

16. Serve your total profession, not just your membership.

Effective networking is very much dependent on the image of the organization. Keep that in mind as you select feasible activities.

At this point, I would like to summarize a plan for developing action strategies on networking;

1. Identify the purpose(s) for networking.

2. Prioritize the purposes, based on the availability of resources and time, on the needs and strengths of the organization.

3. Anticipate your outcomes.

4. Determine how you will measure the success of the outcome.

5. Outline short range, achievable objectives to accomplish purposes.

6. Identify who will have responsibility for monitoring or coordinating activities leading to the accomplishement of the purposes.

Keeping in mind the definition of networking, "the exchange of information or services among individuals, groups, or institutions," there are some key questions that must be addressed by the National Society:

1. What do we have to exchange with other groups or organizations?

2. Is the organization's current structure well enough established to compete with other groups or organizations?

3. What organizational changes should take place within the Society to advance its objectives and mission?

4. Is the Society prepared financially to effectively network with governmental and nongovernmental agencies on key health and medical issues?

5. If the answer is "no" to number four, what activities can be initiated that will be effective, and yet fall within the capabilities and/or limitations of the Society as it currently stands?

In deciding on the answers to these questions, we may want to entertain the following considerations when planning future Society activities:

1. Consider broadening the scope and mission of the Society, to address not only Blacks and minorities in allied health, but the issues or potential issues affecting allied health professionals and educators as they relate to the total health arena. For example, the affect of Medicare payments to the hospital on the practice of allied health professionals in health care facilities and training institutions; determine the implicaton, if any, of the new prospective payment plans for allied health professionals.

2. Consider exploring the possibility of joining other national organizations with similar interests, in forming coalitions, tasks forces, etc., to address the health care needs of Blacks and other minorities on the national scale.

3. Consider sponsoring or co-sponsoring a national meeting or forum to discuss the "status of health care in Black America."

4. Consider establishing a National Advisory Council to the National Society or seek to have representation on existing councils/committees of other organizations.

5. Consider including public members and students on the Society's Executive Committee and Standing Committees. Public members should represent disciplines other than allied health, such as business, hospital administration, public relations, marketing specialists, medicine, dentistry, college presidents, etc.

6. Consider focusing future annual meetings on topics having either regional, or national interests, with prominent speakers who have received national interests, and with prominent speakers who have received national recognition.

7. Consider establishing communication networks with monthly, quarterly, semi-annually published newsletters or bulletins.

8. Consider marketing promotional items for fund raising purposes during meetings.

9. Consider having the Mayor of the city of the next annual meeting proclaim "National Society of Allied Health Day or Week," especially in such cities as Chicago, Philadelphia, Birmingham, Los Angeles, Washington, D.C., Atlanta and, of course, Norfolk, Virginia.

To paraphrase a statement by John Naisbett, "If organizations hold on to what they've been doing, or what has been done in the past because that is what worked, they are absolutely out of business." In the past, we as a people have done too much "micro-thinking" and as a result, we've achieved "micro-successes" or none at all. If this organization is going to do some effective networking, there are some very serious conscious commitments and decisions that will have to be made and some very thoughtful long-range and short-range plans that will have to be decided on and implemented.

To network effectively we must be able to compete with and serve other organizations. Power does respect power, and one of the questions that is often asked is "What can you (or your organization) do for me (or my organization)?" It is my contention that we must start to think and plan in "macro" terms. Either we pull together to survive as a coalition of people, organizations and educational institutions for the betterment of life and health of Black America, or we will fall. Because we are who we are, when one of us falls, invariable we all fall.

The signs have been very clear since 1980. The current political climate has made it unbearable; we have lost a lot, but we've survived worse in the past. It appears that the stimulus to improving the quality of life and health for Blacks and other minorities will lie in the ability of Black people to tilt the balance of political power. The major changes affecting the health and livelihood of minories have been brought about largely by governmental regulations. If we are to compete we must become politically active as individuals and as an organization. We must establish and maintain a strong liaison with other organizations, most of whom will not have the same mission, goals or purposes of the National Society. This being a fact of life, the Society must move forward in its plans and prepare to compete as a advocate for health policy affecting Blacks and other minorities.

In closing, I would like to read to you a news release that should appear in every newspaper in the country in the year 1988. This will give you some idea of the outcomes I would like to see from our efforts of networking:

> The coalition of Black and Minority Health and Medical Organizations is holding its Annual Meeting in Atlanta this week. The major order of business before the group will be to endorse one of the three presidential candidates. Each of the candidates will address the plenary sessions of the meeting scheduled for the next three days. The coalition, which is composed of delegates from the National Society of Allied Health, NAACP, National Medical Association, National Urban League, and the National Dental Association, to name a few, has been very active in lobbying for health and medical legislation that will benefit Blacks and other minority groups. Presidential candidates view this endorsement as pivotal in their bid for the White House. Realizing the impact of Jesse Jackson's candidacy and his "Rainbow Coalition" in the last election, where Jackson delegates, though few in number, were able to determine the eventual candidate to be elected, all candidates are working hard to get the coalition's support. The coalition's Political Action Committee has been quite active in state and national political activities and has been represented at a number of health legislation hearings.

This is my perception of an outcome to effective networking and represents the results of implementing the kinds of strategies that impact on the health of Black people and other minorities. It may be that some of you feel the news release is a little exaggerated and out of focus with the mission of the National Society. I don't think so. Whatever strategies we decide on,

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whether it's today or six months from now, we must plan with the purpose in mind of improving the overall health care of our constituents and families.

I would like to point out the importance of your tasks in the breakout session to follow. I would hope that the recommendations and strategies for networking that are developed, will receive the undivided attention of the Society's Executive Committee. I would also anticipate that the deliberations in the breakouts will be conducted with the understanding that the recommendations will be reviewed and acted on by the Executive Committee, as soon as possible after the meeting has concluded, with a written report provided to each of the conference participants.

I hope my purpose to stimulate your thinking about the tasks to follow has been achieved. The first outcome has been accomplished by our presence here today. I am sure with your ideas and wisdom, the National Society will move forward in meeting its stated mission and successfully satisfying its goals.

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GROUP SESSIONS

AND

RECOMMENDATIONS

ACTION RECOMENDATIONS

The purpose of this section is to present the conference recommendations. These recommendations are advanced in an effort to provide effective networking among and between institutions concerned with increasing minority group member participation in allied health education. Further, the recommendations are consistent with the conference objectives which were to:

1. identify benefits of sharing resources in the development and maintenance of allied health programs,
2. provide information as well as the model programs for developing allied health programs,
3. provide action recommendations and strategies to establish a network among and between institutions concerned with educating minority group members in allied health, and
4. promote minority participation in seeking leadership positions within the allied health field.

Finally, it was the National Society of Allied Health membership that urged the Federal Government to provide financial assistance where feasible and practical in support of these recommendations.

RECOMMENDATIONS

1. The National Society of Allied Health should promote programs to increase the number of Black Americans in the field of Allied Health as leaders, administrators, educators, practitioners, and community health role models. This recommendation can be achieved by:

    1.1 Developing a network of institutions that have a commitment to the purpose of the National Society of Allied Health.

    1.2 Developing a computerized network among these institutions to disseminate and share information specific to the objectives of the network.

    1.3 Developing six (6) regional centers in order to expand community health, educational, financial, and other services provided by the National Society of Allied Health.

    1.4 Developing and maintaining a national clearinghouse and bank of information on early identified Black students who show an interest in Allied Health, as well as, on Black professionals in the field of Allied Health.

    1.5 Developing video tapes, slide tapes, brochures, and picturatory bibliography depicting Black Allied Health professionals participating in responsible roles as leaders, community health providers, administrators, educators, etc.

    1.6 Sponsoring and co-sponsoring health fairs and career day activities with Black churches and other Black organizations.

    1.7 Launching pilot programs to test the effectiveness of deployment into underserved communities, faculty exchanges among and between minority and majority institutions should be developed.

    1.8 Instituting programs designed to track minority students through training in traditionally minority vs traditionally white institutions.

2. The National Society of Allied Health should conduct a series of leadership development activities (workshops and seminars) for allied health educators and administrators in historically and predominantly Black institutions.

    2.1 The NSAH will conduct a survey of leadership development, interest and needs among allied health educators and administrators in historically and predominantly Black institutions.

    2.2 From the survey results a series of specific leadership workshops and seminars will be planned and presented.

    2.3 Conduct a study to determine the impact of minority institutions on an overall allied health manpower pool.

3. The NSAH should conduct a study on the employment patterns for all types of settings and fields of practices and devise regional networking strategies based on these patterns.

4. Develop a journal or related publication to encourage the dissemination of research information regarding minority recruitment, retention and graduation programs and other scholarly articles which relate to minority allied health manpower issues.

5. To promote allied health and the National Society of Allied Health.

    5.1 Establish and/or identify a coordinator at each institution area or region.

    5.2 Development a network of local student institutional chapters of the NSAH with appropriate ceremonies for formal student induction.

    5.3 Initiate a slogan/poster contest amongst faculty and students at the various insitutions for NSAH slogan.

    5.4 Develop network and alliances with larger organizations, i.e. National forum of Black Mayors.

    5.5 Institute an annual event to be coordinated with National Black History month to commemorate Black accomplishments in allied health.

6. To conduct a historical research project to chronicle the accomplished and major contributions of Blacks and other minority groups to the field of allied health education and practice.

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From 1975-1983, Dr. Douglas was Associate Dean and Associate Professor, Howard University, College of Allied Health Sciences. He served in the capacity of Acting Dean 1981-82 while the Dean was on sabbatical leave.

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Dr. Douglas has authored and co-authored numerous publications; the most recent was in the Spring 1983 issue of the

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Journal of Allied Health, entitled, "Changing the Guard: A Methodology for Leadership in Transition."

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Dr. Flack earned his B.S. in Physical Therapy at Ohio State University in 1965; the M.S. degree in Rehabilitation Counseling was earned in 1968 at Kent State University, and the Ph.D. in Counselor-Education was earned in 1971 from State University of New York.

Dr. Flack has authored publications concerning allied health topics in the *Urban Health Magazine*, the *Journal of Allied Health* and others. He serves on the Executive Board of the National Society of Allied Health.

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Dr. Everlena M. Holmes, a native of Tuskeegee Institute, Alabama, is President of the National Society of Allied Health. She is a member of the medical record profession and is currently the Director of the Medical Records Administration Program at George Washington University. Dr. Holmes has developed and directed eight medical record education programs throughout the United States and in Barbados, West Indies. Prior to coming to George Washington University in January, 1984, Dr. Holmes served as the Assistant Dean of Tennessee State University/Meharry Medical College School of Allied Health Professions.

She holds an Ed.D. in Education Administration with emphasis in Higher Education Administration from Virginia Polytechnic Institute and State University; a M.Ed. in Allied Health Education and Administration from the University of Houston in consortium with Baylor College of Medicine; and a B.S. in Business Education from Kentucky State University.

Dr. Holmes is also a graduate from the United States Public Health Service School of Medical Record Administration and participates at the national, local and state levels in activities affecting the delivery of health care services to minorities; more specifically, Blacks and Native Americans.

Dr. Holmes has a sincere commitment to improving the health status of Black Americans through research, education and employment.

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Alvin J. McNeil, Ed.D., has been with Texas Southern University since 1971. He has been Professor and Chairman, Foundations and Higher Education since 1981.

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Dr. McNeil has received numerous honors and wards, among which are the following:

- Nominated for membership in Who's Who in American Colleges and Universities - 1946
- Listed in Who's Who in the South and Southwest - 1963
- Listed in Dictionary of International Biography and American Men of Science - 1963
- Listed in Who's Who in Black America - 1977
- Distinguished Service Award - Phi Beta Sigma Fraternity - 1978
- Elected Chairman of The Black Caucus of the American Association of Higher Education - 1980.

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Dr. Scott is an active member of several professional and scientific societies, including the American Society of Radiologic Technology, the Texas Society of Allied Health Professions and the American Society of Allied Health Professions. She has served on various committees and task forces, including recent service with the Education and Research Committee of the American Society of Radiologic and Leadership Development of the American Society of Allied Health Professions.

Dr. Scott has served as Editor of the Journal of Radiology Technology and as Co-Editor of the TSAHP Newsletter. She was a member of the Board of Director of TSAHP from 1978-1981. She is actively involved with consultation and accreditation activities within Radiologic Technology Education, and has published or presented numerous scientific papers on a broad range of topics in allied health education. Dr. Scott is married and resides in Clear Lake City, Texas.

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Dr. Simpson is a charter member of the Federal Government's new Senior Executive Services (SES) and is a recent recipient of a

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1983 bonus award made to SES members for outstanding service by the Secretary of the Department of Health and Human Services. Dr. Simpson is a life member of Kappa Alpha Psi Fraternity.

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In 1979, she was the recipient of the Office of Education's Superior Services Award, and she was awarded the Department of HEW's Certificate for Outstanding Performance in March 1979. In June of 1971, she was appointed Chairperson of the Commissioner's Task Force on Women's Employment Rights. She is an elder in the Presbyterian Church of Educators, the Black Higher Education Discussion Group, the Coalition of 100 Black Woman in D.C., Inc., the Community Advisory Committee of Howard University's Cancer Research Center, Blacks in Government, the NAACP, Association of Black Women in High Education, the Association of Retarded Citizens, a board member of Junior Achievement of the District of Columbia, and she is listed in Who's Who Among Black Americans.

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